

AMENDED

MEDICAL REVIEW – NORTH I SECTION
AUDITS AND INVESTIGATIONS
DEPARTMENT OF HEALTH CARE SERVICES

REPORT ON THE MEDICAL AUDIT OF

KP Cal, LLC
Kaiser Permanente GMC

Contract Number: 07-65849 Sacramento
09-86159 San Diego

Audit Period: September 1, 2017
Through
August 31, 2018

Report Issued: May 20, 2019

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I. INTRODUCTION

Kaiser Foundation Health Plan, Inc. (KFHP) obtained its Knox-Keene license in November 1977 and contracted with the Department of Health Care Services (DHS at the time) in 1994 as a Geographic Managed Care (GMC) plan to provide health care services to Medi-Cal beneficiaries in the GMC counties of Sacramento and San Diego.

In 2005, KP Cal, LLC (Plan) was created and licensed as a Knox-Keene plan to hold Kaiser's GMC Contracts. The Department of Health Care Services (DHCS) then transferred the GMC Contracts to KP Cal, LLC. At that time, KP Cal, LLC and KFHP entered into a management and administrative services agreement to delegate administrative and operational functions such as quality improvement, grievances, and appeals to KFHP. These two entities also entered into a health services agreement to provide health care services to KP Cal, LLC members through KFHP's network of providers and medical centers. KFHP offers a comprehensive health care delivery system including physicians, medical centers, hospitals, laboratories, and pharmacies.

KFHP divides its operations into Northern California (NCAL) and Southern California (SCAL) regions with corresponding responsibilities for the Sacramento and San Diego GMC Contracts. The Sacramento GMC service area includes Sacramento County and members in Amador, El Dorado, and Placer counties who were either previously enrolled or family-linked with Kaiser. The San Diego GMC service area includes San Diego County.

As of August 2018, KFHP's total direct GMC Contract membership was approximately 130,417. Medi-Cal membership composition was 78,923 for GMC Sacramento and 51,494 for GMC San Diego.

The scope of this audit includes the review of Seniors and Persons with Disabilities (SPD) population in the areas of Utilization Management, Access and Availability of Care, Member's Rights, and Quality Management.

II. EXECUTIVE SUMMARY

This report presents the audit findings of the DHCS medical audit for the period of September 1, 2017 through August 31, 2018. The onsite review was conducted from October 1 through October 12, 2018. The audit consisted of document review, verification studies, and interviews with Plan representatives.

An Exit Conference was held on April 18, 2019 with the Plan. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the draft audit report findings. The Plan submitted a response after the Exit Conference. The results of our evaluation of the Plan's response are reflected in this report.

The audit evaluated five categories of performance: Utilization Management (UM), Access and Availability of Care, Member Rights, Quality Management, and Administrative and Organizational Capacity.

The prior DHCS medical audit (for the period of September 1, 2016 through August 31, 2017) was issued on March 26, 2018. This audit examined documentation for compliance and to determine to what extent the Plan has implemented their Corrective Action Plan (CAP).

Findings denoted as repeat findings are uncorrected deficiencies substantially similar to those identified in the previous audit.

This is a combined report for both the Sacramento GMC Contract and San Diego GMC Contract. Common findings and recommendations are reported under **Sacramento and San Diego GMC**. Unique findings and recommendations are specified as either **Sacramento GMC** or **San Diego GMC**.

The summary of the findings by category follows:

Category 1 – Utilization Management

Sacramento GMC

The Plan shall ensure there is a set of written criteria or guidelines for utilization review that is based on sound medical evidence, is consistently applied, regularly reviewed, and updated. The Plan used outdated criteria and criteria inconsistent with Medi-Cal guidelines to review prior authorization requests (PA).

San Diego GMC

The Plan is required to ensure that it consistently applies evidence based written criteria or guidelines in reviewing prior authorization requests. The Plan denied PAs based on inconsistent application of Medi-Cal criteria. The Plan did not follow its stated practice of discussing potential denials with the requesting specialist.

The Plan is required to ensure the final decision maker of an appeal involving clinical issues is a health care professional that has not participated in any prior decisions related to the appeal. The Plan allowed the same health care professional who had participated in a prior decision about a denial to decide the appeal.

The Plan is required to provide or arrange for all medically necessary services required in this Contract. The Plan may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition. The Plan made appeal decisions without documenting use of established criteria, and upheld denials of medically necessary services.

Category 3 – Access and Availability of Care

Sacramento and San Diego GMC

Category 3 covers appointment procedures and monitoring wait times for routine, urgent and emergency care appointments and access to specialist and specialty care.

The Plan is required to provide a printed provider directory upon request. The provider directory needs to include the complete provider information and whether the provider is accepting new patients. The Plan did not maintain a printed provider directory available to members.

Category 3 also includes requirements and procedures for processing emergency service claims and family planning service claims.

The Plan is required to reimburse non-contracting family planning providers at no less than the equivalent Medi-Cal FFS rate. The Plan paid non-contracted family planning services at less than the Medi-Cal Fee-for-service rate.

For each claim that is either denied, adjusted or contested, the Plan is required to provide an accurate and clear written explanation of the specific reasons for the action taken. The Plan did not disclose the specific rationale used in determining why claims were rejected or denied.

Category 4 – Member’s Rights

Sacramento and San Diego GMC

Category 4 covers procedures and requirements to establish and maintain a grievance system.

The Plan is required to address and resolve all issues presented in a member grievance. The Plan closed cases without addressing and resolving all issues presented in a member’s grievance.

The Plan’s written resolution to the member is required to contain a clear and concise explanation of its decision. The Plan sent grievance resolution letters without clear and concise descriptions of the Plan’s decisions.

The Plan is required to ensure the written record of grievances is reviewed periodically by the governing body of the plan. This review is required to be thoroughly documented. The Plan did not document periodic review of GMC Medi-Cal Managed Care grievances by the Quality and Health Improvement Committee (QHIC), as designated by the governing body.

Category 4 includes requirements for appropriate handling and reporting of protected health information. The Plan is required to immediately investigate each security incident, breach, or unauthorized use of disclosure of protected health information (PHI) or confidential data and report it within 72 hours of the discovery. The Plan did not notify DHCS of suspected security incidents and unauthorized use of PHI within 72 hours of the discovery.

Sacramento GMC

The Plan is required to provide or arrange for members all medically necessary and other services required in this contract and ensure it provides services in an amount no less than that offered to Medi-Cal Fee-For-Service beneficiaries. The Plan may not arbitrarily deny a required service solely because of the diagnosis, type of illness, or condition. The Plan arbitrarily denied medically-necessary services requested through the grievance process.

San Diego GMC

The Plan is required to provide or arrange for members all medically necessary and other services required in this contract and ensure it provides services in an amount no less than that offered to Medi-Cal Fee-For-Service beneficiaries. The Plan may not arbitrarily deny a required service solely because of the diagnosis, type of illness, or condition. The Plan denied clinical services to members requested through the grievance process without documenting the application of established, evidence-based criteria and without following contractual requirements. Services included those for which evidence-based criteria existed.

Category 5 – Quality Management

Sacramento and San Diego GMC

Category 5 covers procedures and requirements to monitor, evaluate and take effective action to address any needed improvements in the quality of care delivered by providers.

The Plan is required to monitor, evaluate, and take effective action to address any needed improvements in the quality of care delivered by all providers rendering services on its behalf. The Plan did not take effective action to address needed improvements in the quality of care when it did not require action after Potential Quality Incidents (PQI) investigations of incidents resulting in serious adverse outcomes for members.

The Plan is required to ensure that it uses the latest edition of the U.S. Preventive Services Task Force's (USPSTF) *Guide to Clinical Preventive Services* as a minimum guideline for delivering preventive services to adult members age 21 or older. The Plan must provide all preventive services identified as USPSTF "A" and "B" recommendations. The Plan did not require that practitioners provide applicable USPSTF "A" and "B" preventive services to members.

Category 5 includes requirements to provide Medi-Cal training to staff. The Plan is required to conduct training for all providers within 10 working days after placing newly contracted providers on active status. The Plan did not provide new provider training for non-physician providers within 10 working days after being placed on active status.

Sacramento GMC

The Plan is required to implement policies that, at a minimum, state the governing body will routinely receive written progress reports from the quality improvement committee. Plan documentation did not show that its governing body received GMC Quality Oversight Committee's written progress reports about quality activities specific to Medi-Cal members.

The Plan's written description of its quality improvement system is required to include an organizational chart showing key staff and committee responsible for Quality Improvement (QI) activities. The Plan did not include the GMC Quality Oversight Committee in its organizational chart or describe the committee in its Quality Program Description.

The Plan did not provide new provider training for physician providers within 10 working days after being placed on active status.

III. SCOPE/AUDIT PROCEDURES

SCOPE

This audit was conducted by the DHCS Medical Review Branch to ascertain that the medical services provided to Plan members comply with federal and state laws, Medi-Cal regulations and guidelines, and the State Contracts.

PROCEDURE

The on-site review was conducted from October 1, 2018 through October 12, 2018 at Kaiser Permanente's regional office in Oakland, California. The audit included a review of the Plan's policies for providing services, the procedures used to implement the policies, and verification studies of the implementation and effectiveness of the policies. Documents were reviewed and interviews were conducted with Plan administrators and staff.

The following verification studies were conducted:

Category 1 – Utilization Management

Prior Authorization Requests: 18 (8 Sacramento GMC and 10 San Diego GMC) medical prior authorization files including 4 seniors and persons with disabilities (SPD) cases, were reviewed for timeliness, consistent application of criteria, and appropriate review. No medications require prior authorization under the Kaiser Utilization Management Program.

Appeal Procedures: 12 (3 Sacramento GMC and 9 San Diego GMC) appeals of denied grievances including 3 SPD cases were reviewed for appropriate and timely adjudication.

Category 3 – Access and Availability of Care

Claims: 58 emergency services and 52 family planning claims were reviewed for appropriate and timely adjudication.

Category 4 – Member's Rights

Grievance procedures: 77 statewide grievances, including 40 standard, 27 quality of care, and 10 expedited were reviewed for timely resolution, response to complainant, and submission to the appropriate level for review. 39 grievances were for SPD members.

Confidentiality Rights: 17 Health Insurance Portability and Accountability Act (HIPAA)/Protected Health Information (PHI) breach and security incidents (12 Sacramento GMC and 5 San Diego GMC) were reviewed for processing and timeliness requirements.

Category 5 – Quality Management

Potential Quality Incidents (PQI): 8 PQIs (5 Sacramento GMC and 3 San Diego GMC) including 3 SPD files from San Diego were reviewed for appropriate adjudication.

Provider Training: 62 new provider training records (31 Sacramento GMC and 31 San Diego GMC) were reviewed for the timeliness of Medi-Cal Managed Care program training.

Category 6 – Administrative and Organizational Capacity

Fraud and Abuse: 10 fraud and abuse cases (5 Sacramento GMC and 5 San Diego GMC) were reviewed for processing and reporting requirements.

A description of the findings for each category is contained in the following report.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: KP Cal, LLC – Kaiser Permanente Sacramento and San Diego GMC

AUDIT PERIOD: September 1, 2017 to August 31, 2018

DATE OF AUDIT: October 1, 2018 to October 12, 2018

CATEGORY 1 - UTILIZATION MANAGEMENT

1.1

UTILIZATION MANAGEMENT PROGRAM/ REFERRAL TRACKING SYSTEM / DELEGATION OF UM / MEDICAL DIRECTOR & MEDICAL DECISIONS

Utilization Management (UM) Program Requirements:

Contractor shall develop, implement, and continuously update and improve, a Utilization Management (UM) program that ensures appropriate processes are used to review and approve the provision of Medically Necessary Covered Services. ...(as required by Contract)

GMC Contract A.5.1

There is a set of written criteria or guidelines for utilization review that is based on sound medical evidence, is consistently applied, regularly reviewed, and updated.

GMC Contract A.5.2.C

Review of Utilization Data:

Contractor shall include within the UM Program mechanisms to detect both under- and over-utilization of health care services. Contractor's internal reporting mechanisms used to detect Member Utilization Patterns shall be reported to DHCS upon request.

GMC Contract A.5.4

Referral Tracking System:

Contractor is responsible to ensure that the UM program includes: ... An established specialty referral system to track and monitor referrals requiring prior authorization through the Contractor. The system shall include authorized, denied, deferred, or modified referrals, and the timeliness of the referrals.

GMC Contract A.5.1.F

Delegated Utilization Management (UM) Activities:

Contractor may delegate UM activities. If Contractor delegates these activities, Contractor shall comply with Exhibit A, Attachment 4, Provision 6. Delegation of Quality Improvement Activities.

GMC Contract A.5.5

Medical Director:

Contractor shall maintain a full time physician as medical director pursuant to Title 22 CCR Section 53913.5 whose responsibilities shall include, but not be limited to...

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: KP Cal, LLC – Kaiser Permanente Sacramento and San Diego GMC

AUDIT PERIOD: September 1, 2017 to August 31, 2018

DATE OF AUDIT: October 1, 2018 to October 12, 2018

1.1

UTILIZATION MANAGEMENT PROGRAM/ REFERRAL TRACKING SYSTEM / DELEGATION OF UM / MEDICAL DIRECTOR & MEDICAL DECISIONS

- A. Ensuring that medical decisions are:
 - 1) Rendered by qualified medical personnel.
 - 2) Are not influenced by fiscal or administrative management considerations.
- B. Ensuring that the medical care provided meets the standards for acceptable medical care.
- C. Ensuring that medical protocols and rules of conduct for plan medical personnel are followed.
- D. Developing and implementing medical policy.
- E. Resolving grievances related to medical quality of care.
- F. Direct involvement in the implementation of Quality Improvement activities.
- G. Actively participating in the functioning of the plan grievance procedures.

GMC Contract A.1.6

Medical Decisions:

Contractor shall ensure that medical decisions, including those by subcontractors and rendering providers, are not unduly influenced by fiscal and administrative management.

GMC Contract A.1.5

SUMMARY OF FINDING(S):

Sacramento GMC

1.1.1 Utilization Management (UM) Program Requirements

The Plan shall ensure the UM Program includes procedures for continuously reviewing the utilization of services and facilities (*Contract, Exhibit A, Attachment 5 (1) (H)*).

The Plan's 2018 *UM Program Description* (UMPD) stated the Plan monitored drug, laboratory, radiology and surgical utilization, thus ensuring proper and judicious distribution of resources in the delivery of health care services.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: KP Cal, LLC – Kaiser Permanente Sacramento and San Diego GMC

AUDIT PERIOD: September 1, 2017 to August 31, 2018

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The Plan did not provide documentation of continuous review of Medi-Cal members' medication utilization:

- Resource Management Committee (RMC) meeting minutes did not document Medi-Cal drug utilization reports.
- The Pharmacy and Therapeutics (P and T) Committee only reported annual Medi-Cal drug utilization in July 2018.
- P and T Committee drug management presentations in September 2017, November 2017, and May 2018 did not separately report Medi-Cal medication use.
- The Medi-Cal Quality Oversight Committee reported Medi-Cal member prescription totals to the KP Cal Board of Directors in December 2017 without specifying details such as types of medications prescribed.

Plan policy *CAPHARM 8.1.2.2 Drug Formulary Processes* did not describe how the Plan monitored or reported Medi-Cal member drug utilization. Plan policy *CAPHARM 8.2.5 Medi-Cal DUR* created in July 2017 stated the Plan provided ongoing retrospective reports to the P and T committees, but did not mention the Northern California Drug Utilization Review Group. In a memo provided after the Exit Conference, the Plan reported the group met every other month and reviewed drug utilization for all lines of business. The Plan did not provide evidence of the meetings or Medi-Cal drug reports reviewed by the group.

When the Plan does not continuously review member utilization data, it may miss opportunities for improved health service delivery to Medi-Cal members.

San Diego GMC

1.1.1 Utilization Management (UM) Program Requirements

The Plan shall ensure the UM Program includes procedures for continuously reviewing the utilization of services and facilities (*Contract, Exhibit A, Attachment 5 (1) (H)*).

The Plan's 2018 UM Program Description (UMPD) stated the Plan monitored drug, laboratory, radiology and surgical utilization, thus ensuring proper and judicious distribution of resources in the delivery of health care services.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: KP Cal, LLC – Kaiser Permanente Sacramento and San Diego GMC

AUDIT PERIOD: September 1, 2017 to August 31, 2018

DATE OF AUDIT: October 1, 2018 to October 12, 2018

The Plan did not have procedures for continuous review of service utilization by Medi-Cal members. The UM for Southern California (UMSC), Pharmacy and Therapeutics (P and T), and San Diego Medi-Cal and State Programs Committee (SD Medi-Cal Committee) meeting minutes did not show regular review of Medi-Cal utilization data:

- UMSC minutes did not document Medi-Cal-specific UM reports.
- The SD Medi-Cal Committee met quarterly; however, meeting minutes documented Medi-Cal utilization data review only in November 2017. The committee reported Medi-Cal utilization patterns to the local quality committee in September 2017 and April 2018.
- UMSC and SD Medi-Cal Committee did not document continuous review of Quarterly *Regional Dashboard* reports or scorecards that contained Medi-Cal utilization data.
- P and T Committee, UMSC and SD Medi-Cal Committee minutes did not document Medi-Cal medication utilization review.

The San Diego Medi-Cal Committee summary, UM Southern California charter, the 2018 UM Program Description and the 2018 UM Work Plan and Plan policy *CAPHARM 8.1.2 Drug Formulary Processes* did not specify how often committees reviewed Medi-Cal UM data.

When the Plan does not continuously review member utilization data, it may miss opportunities for improved health service delivery for Medi-Cal members.

Sacramento GMC

1.1.2 Referral Tracking

The Plan shall ensure the UM program includes an established specialty referral system to track and monitor referrals requiring prior authorization through the Plan. The system shall include authorized, denied, deferred or modified referrals and the timeliness of the referrals (*Contract, Exhibit A, Attachment 5 (1) (F)*).

The Plan's 2018 *UM Work Plan* stated the Plan tracked the timeliness of UM decisions and notifications.

The Plan did not have a system to track authorized Prior Authorizations (PAs) to their completion.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: KP Cal, LLC – Kaiser Permanente Sacramento and San Diego GMC

AUDIT PERIOD: September 1, 2017 to August 31, 2018

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Plan policies did not describe a referral tracking process for approved PAs. Reports tracked the timely resolution of Medi-Cal service requests and timeliness of member notification.

In an interview, the Plan acknowledged it did not track open authorizations to completion on a system-wide basis.

When the Plan does not track all approved PAs to completion, it may not learn how many and why some needed services are not delivered.

San Diego GMC

1.1.2 Referral Tracking

The Plan shall ensure the UM program includes an established specialty referral system to track and monitor referrals requiring prior authorization through the Plan. The system shall include authorized, denied, deferred or modified referrals and the timeliness of the referrals (*Contract, Exhibit A, Attachment 5 (1) (F)*).

The Plan's 2018 UM Work Plan stated it tracked the timeliness of UM decisions and of notification for all denials.

The Plan did not have a system to track authorized Prior Authorizations (PAs) to their completion.

Plan policies did not describe a referral tracking process for approved PAs. Reports tracked the timely resolution of Medi-Cal service requests and timeliness of member notification.

In an interview, the Plan acknowledged it did not track open authorizations to completion.

When the Plan does not track approved PAs to completion, it may not learn how many and why some needed services are not delivered.

Sacramento GMC

1.1.3 Oversight of Utilization Management Delegation

The Plan is accountable for all delegated UM functions and responsibilities (*Contract, Exhibit A, Attachment 4 (6) (A)*).

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: KP Cal, LLC – Kaiser Permanente Sacramento and San Diego GMC

AUDIT PERIOD: September 1, 2017 to August 31, 2018

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Member Notice of Action (NOA) letters communicating UM decisions to deny, modify, or defer requested health care services shall comply with *Health and Safety Code 1367.01 (Contract, Exhibit A, Attachment 13 (8) (A))*.

NOA letters shall contain a clear and concise explanation of the reason for the Plan's decision, shall include the guidelines used, and include the clinical reasons for the decision (*Health and Safety Code 1367.01(h) (4)*).

The Plan's 2018 *UM Program Description* (UMPD) stated the Plan delegated UM processes, including service authorization and writing NOA letters, to a chiropractic and acupuncture provider. It further stated the Plan's Resource Management Committee (RMC) oversaw UM delegation.

The Plan was deficient in its oversight of a delegated entity's NOA letter writing. The Plan did not ensure the delegate met the requirements for clear and concise NOA letters.

A verification study of eight PA cases included three denials from a delegate. All three revealed unclear and not concise NOA letters:

- NOA letters contained long and complicated explanations of the Plan's decision
- NOA letters did not specify the guideline used to deny services. For example, a letter denying chiropractic services cited multiple references as reasons for the decision.

The 2018 UMPD stated the Plan regularly reviewed its delegate's denial files, and policies and procedures. The Plan's RMC noted the Plan's 2017 audit identified deficient templates and appeal rights information in the delegate's NOA letters. The findings included NOA content. However, additional documentation submitted after the Exit Conference did not specifically address length and clarity.

Unclear letters resulting from deficient Plan oversight may confuse members and leave them without the tools to make informed health care decisions.

RECOMMENDATION(S):

Sacramento GMC

- 1.1.1** Develop and implement procedures to ensure continuous review and documentation of Medi-Cal members' medication utilization.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖
PLAN: KP Cal, LLC – Kaiser Permanente Sacramento and San Diego GMC
AUDIT PERIOD: September 1, 2017 to August 31, 2018 DATE OF AUDIT: October 1, 2018 to October 12, 2018

San Diego GMC

- 1.1.1 Develop and implement procedures to ensure the Plan documents continuous review of Medi-Cal members' utilization of services; ensure continuous review and documentation of medication utilization.

Sacramento and San Diego GMC

- 1.1.2 Develop and implement policies to ensure the Plan tracks approved PAs to their completion.

Sacramento GMC

- 1.1.3 Revise Plan oversight processes to ensure delegates' member NOA letters comply with contractual requirements.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: KP Cal, LLC – Kaiser Permanente Sacramento and San Diego GMC

AUDIT PERIOD: September 1, 2017 to August 31, 2018

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1.2

PRIOR AUTHORIZATION REVIEW REQUIREMENTS

Prior Authorization and Review Procedures:

Contractor shall ensure that its pre-authorization, concurrent review and retrospective review procedures meet the following minimum requirements...(as required by Contract)

GMC Contract A.5.2.A, B, D, F, H, and I.

Exceptions to Prior Authorization:

Prior Authorization requirements shall not be applied to Emergency Services, Minor Consent Services, family planning services, preventive services, basic prenatal care, sexually transmitted disease services, and HIV testing.

GMC Contract A.5.2.G

Timeframes for Medical Authorization:

Pharmaceuticals: 24 hours or one (1) business day on all drugs that require prior authorization in accordance with Welfare and Institutions Code Section 14185(a)(1) or any future amendments thereto.

GMC Contract A.5.3.F

Routine authorizations: five (5) working days from receipt of the information reasonably necessary to render a decision (these are requests for specialty service, cost control purposes, out-of-network not otherwise exempt from prior authorization) in accordance with Health and Safety Code Section 1367.01(h)(1), or any future amendments thereto, but, no longer than 14 calendar days from the receipt of the request. The decision may be deferred and the time limit extended an additional 14 calendar days only where the Member or the Member's provider requests an extension, or the Contractor can provide justification upon request by the State for the need for additional information and how it is in the Member's interest. Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such.

GMC Contract A.5.3.H

Denial, Deferral, or Modification of Prior Authorization Requests:

Contractor shall notify Members of a decision to deny, defer, or modify requests for Prior Authorization by providing written notification to Members and/or their authorized representative...This notification must be provided as specified in 22 CCR Sections 51014.1, 51014.2, and 53894, and Health and Safety Code Section 1367.01.

GMC Contract A.13.8.A

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: KP Cal, LLC – Kaiser Permanente Sacramento and San Diego GMC

AUDIT PERIOD: September 1, 2017 to August 31, 2018

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SUMMARY OF FINDING(S):

Sacramento GMC

1.2.1 Transplant Evaluation Requests

The Plan shall refer potential major organ (except for kidney) transplant candidates to a Medi-Cal approved transplant center of excellence (COE). If the transplant center physician considers the member to be a suitable candidate, the Plan shall submit a prior authorization request for transplantation (*Contract, Exhibit A, Attachment 11 (18) (B)*).

Plan policy *Health Plan UM 4.0 Outside Services and Second Opinion* stated the Plan routed transplant referrals to the appropriate Transplant Board which reviewed the case and approved or denied the request.

The Plan required extensive medical assessment of members before referring them for transplant evaluation at centers of excellence. The contract does not require establishing transplant suitability, only identification as a potential candidate for transplant, before member referral to a transplant center for evaluation.

The Plan's undated draft policy *Medi-Cal Managed Care Member Disenrollment Requests Due to Organ Transplant* stated physicians referred members they diagnosed and identified as potential transplant candidates to the Plan's Transplant Committee. A sample GI/Liver transplant referral showed pre-transplant evaluation included tests and social history questions not required for determining potential for transplant candidacy.

In interviews, the Plan reported that specialists who identified potential organ transplant candidates could not directly refer the member to a transplant center for evaluation. The Plan required completion of all steps in a pre-evaluation before it would approve a potential transplant candidate for transplant center evaluation. The Plan reported that it was a partner to the transplant centers, performing necessary pre-transplant assessment steps.

After the Exit Conference, the Plan submitted a copy of DHCS policy letter 97-07 *Major Organ Transplant* stating that primary care providers must ensure a member is a potential major organ transplant recipient through diagnostic testing and specialist referral. The transplant center physician determines suitability for transplant. The Plan asserted that the policy letter's instructions required them to thoroughly test members before referral to COE for evaluation. However, the letter stated that Plans should test to establish potential for transplant; the COE was responsible for transplant suitability.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: KP Cal, LLC – Kaiser Permanente Sacramento and San Diego GMC

AUDIT PERIOD: September 1, 2017 to August 31, 2018

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Excessive requirements may delay needed expert evaluations and organ transplantation.

San Diego GMC

1.2.1 Transplant Evaluation Requests

The Plan shall refer potential major organ (except for kidney) transplant candidates to a Medi-Cal approved transplant center of excellence. If the transplant center physician considers the member to be a suitable candidate, the Plan shall submit a prior authorization request for transplantation (*Contract, Exhibit A, Attachment 11 (18) (B)*).

The Plan's 2018 *UM Program Description* (UMPD) stated Plan transplant committees reviewed cases referred for transplant evaluation using selection criteria developed through current medical literature, research and knowledge.

The Plan required extensive medical assessment of members before referring them for transplant evaluation at centers of excellence. The contract did not require establishing transplant suitability, only identification as a potential candidate for transplant, before member referral to a transplant center for evaluation.

The Plan's undated policy *UM 1.1 Medi-Cal Managed Care Member Disenrollment Requests Due to Organ Transplant* stated physicians referred diagnosed potential transplant candidates to the Plan's transplant specialist. The specialist assessed whether the member met criteria for transplantation and directed the case to the Transplant Hub, which referred the case to the Transplant Committee. The committee either approved or denied member evaluation at a transplant center. A sample GI/Liver transplant referral showed pre-transplant evaluation included tests and social history questions not required for determining potential for transplant candidacy.

In interviews, the Plan reported that specialists who identified potential organ transplant candidates could not directly refer the member to a transplant center for evaluation. The Plan required completion of all steps in a pre-evaluation before it would approve a potential transplant candidate for transplant center evaluation. The Plan reported that it was a partner to the transplant centers, performing necessary pre-transplant assessment steps.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: KP Cal, LLC – Kaiser Permanente Sacramento and San Diego GMC

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After the Exit Conference, the Plan submitted a copy of DHCS policy letter *97-07 Major Organ Transplant* stating that primary care providers must ensure a member is a potential major organ transplant recipient through diagnostic testing and specialist referral. The transplant center physician determines suitability for transplant. The Plan asserted that the policy letter's instructions required them to thoroughly test members before referral to COE for evaluation. However, the letter stated that Plans should test to establish potential for transplant; the COE was responsible for transplant suitability.

Excessive requirements may delay needed expert evaluations and organ transplantation.

Sacramento GMC

1.2.2 Prior Authorization Decisions

The Plan shall ensure there is a set of written criteria or guidelines for utilization review that is based on sound medical evidence, is consistently applied, regularly reviewed, and updated (*Contract, Exhibit A, Attachment 5 (2) (C)*).

The Plan shall ensure that it provides the services required in this contract in an amount no less than that offered to beneficiaries under the Medi-Cal Fee-For-Service (FFS) Program (*Contract, Exhibit A, Attachment 10 (10) (A)*).

Plan policy *RM-UM 1.0 UM Prior Authorization (PA)*, and *UM Criteria* stated that the Plan developed or adopted objective, measurable UM criteria that it annually reviewed and updated as necessary.

The Plan used outdated criteria and guidelines inconsistent with Medi-Cal in reviewing PA requests.

A verification study of eleven PA requests revealed deficiencies in the Plan's Utilization Management PA criteria and their application:

- In two cases, the Plan used criteria last updated in 2014 and denied requests for protective helmets. The Plan's guidelines limited the item to members with anatomic deficits, while Medi-Cal Fee-for-Service did not. In both cases, members displayed self-harming behaviors and medical necessity for protective devices.
- In two cases, the Plan used criteria last updated in 2014 and denied requests for custom foot orthotics, which Medi-Cal covers for members without diabetes. The Plan did not document annual review of the criteria.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: KP Cal, LLC – Kaiser Permanente Sacramento and San Diego GMC

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- In one appealed UM denial, the Plan's required a member be ambulatory (able to walk) to qualify for a portable oxygen canister whereas Medi-Cal criteria only required mobility (ability to move about). The member utilized a motor scooter; the Plan's criteria were stricter than Medi-Cal's.
- In another appealed UM denial, the Plan classified an electronic lift as a convenience and denied a replacement battery as a luxury item, though it moved the member with spinal problems, cerebral palsy and epilepsy from bed to wheelchair. Documentation did not show that the Plan referred the case to California Children's Services (CCS) to cover the battery. CCS originally provided the lift; Medi-Cal covers electronic lifts for CCS clients.

The Plan's Behavioral Health Treatment (BHT) criteria conflicted with Medi-Cal:

- The Plan's *2018 BHT for Autism Spectrum Disorder (ASD)* criteria allowed discontinuation of BHT for insignificant progress, minimally involved or obstructive caregiver, or member inability to participate.
- DHCS's APL 18-006 allowed BHT discontinuation upon achieving treatment goals, for goals not met, or when services were not medically necessary. The term "Not medically necessary" meant no expectation of continued clinical benefit.
- The Plan's criteria for BHT discontinuation did not match Medi-Cal criteria until the revision to plan policy *BHT Coverage for Medi-Cal Members Under 21* effective 8/1/2018, the last month of the audit period.

Plan policy *RM-UM 1.0* stated the Plan used Medicare regulations for Medi-Cal member requests; members' Medi-Cal Evidence of Coverage (EOC) described exceptions.

The UMPD noted the Plan developed its own evidence based UM criteria, which the Resource Management Committee (RMC) and the Quality Oversight Committee (QOC) reviewed annually and updated as needed.

The Plan's GMC Quality Oversight Committee (GMC QOC) charter noted the committee reviewed, evaluated and recommended written policies, procedures, protocols and criteria for the Medi-Cal line of business. GMC QOC meeting minutes did not document review of Medi-Cal UM criteria.

Using outdated UM criteria and criteria inconsistent with Medi-Cal's may result in denials of medically necessary covered services and adverse health outcomes for Medi-Cal members.

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1.2.2 Prior Authorization decisions

The Plan shall ensure that it consistently applies evidence based written criteria or guidelines in reviewing prior authorization, concurrent and retrospective service requests (*Contract, Exhibit A, attachment 5 (2) (C)*).

APL 15-012 *Dental Services – Intravenous Sedation and General Anesthesia Coverage* stated behavioral techniques, local anesthesia, and conscious sedation should be tried first for dental procedures. It allowed general anesthesia when primary methods had been tried and failed, were not feasible, or for exceptions such as inability to immobilize the patient, extensive dental treatment requiring more than local anesthesia or conscious sedation, acute anxiety, or lack of patient cooperation. The APL recommended treatment in a hospital or other facility that could treat serious medical crises if dental patients had asthma or heart arrhythmias.

Plan policy *SC.RUM.016 UM Denial of Practitioner Requested Services* stated the Plan used UM criteria to assist with determinations of medical necessity. Plan policy *SC.RUM.011 UM Criteria and Guidelines* stated the Plan used Medi-Cal regulations for Medi-Cal member UM decisions.

The Plan inconsistently applied Medi-Cal criteria and denied prior authorizations. The Plan did not follow its stated practice of discussing potential denials with requesting specialists.

A verification study of five denied PAs revealed processing deficiencies in two cases:

- In one example, a surgeon requested general anesthesia for a member with asthma, arrhythmias, sleep apnea and obesity, who could not have impacted wisdom teeth removed in an office setting. The Plan did not follow Medi-Cal criteria, which allows consideration for general anesthesia without requiring local anesthesia or conscious sedation first if the latter two are not feasible.
- In another case, a specialist requested general anesthesia for an autistic patient who could not sit still for dental procedures; the Plan denied the request without contacting the provider for more information. The Plan did not follow Medi-Cal criteria allowing general anesthesia for a member who could not be immobilized or was uncooperative.

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In an interview, the Plan stated that Medi-Cal policy required trial and failure of local anesthesia before approval of general anesthesia. It acknowledged it did not follow its policy of calling providers to obtain more information before issuing denials in the above cases.

When the Plan deviates from Medi-Cal guidelines and its own PA processes, members may not receive medically necessary covered services.

San Diego GMC

1.2.3 Member Notice of Action (NOA) Letters

The Plan shall notify members of a decision to deny, defer, or modify requests for prior authorization by sending written notification that complies with Health and Safety Code (HSC) 1367.01 (*Contract, Exhibit A, Attachment 13 (8) (A)*).

The Plan's written notice to members shall explain the reasons for the action clearly and concisely (*HSC 1367.01*).

Plan policy *SC.RUM.016 UM Denial of Practitioner Requested Services* stated member denial letters contained "easy to understand language explaining the reason for the denial, including a reference to the UM criteria, benefit provision, clinical guideline or protocol used in the determination."

The Plan's member NOA letters were unclear and unnecessarily long. NOA letters inaccurately described the Plan's decisions.

A verification study showed deficiencies in five NOA letters:

- Letters contained long lists of criteria, lengthy translations of medical terms, redundant elements and grammatical errors.
- Letters used high-level language.
- Letters did not accurately explain the Plan's rationale or quoted Medicare rather than Medi-Cal criteria. As an example, a surgeon planned to repair a member's malformed jaw and remove her impacted wisdom teeth at the same time in an out-of-Plan facility. The provider requested approval of general anesthesia for the long procedure. The Plan sent two denial letters that did not clearly convey the Plan's preference for separate and less traumatic procedures instead of one long surgery, its finding that jaw repair could be performed in-plan, and the decision that tooth extraction could now be completed under local anesthesia.

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Plan policy *SC.RUM.016* did not describe the letter writing process.

Unclear and confusing letters about the Plan's healthcare decisions may lead to members making uninformed health care decisions.

RECOMMENDATION(S):

Sacramento and San Diego GMC

- 1.2.1** Revise Plan policies to ensure that potential transplant candidates are referred to transplant centers for evaluation without requiring a Plan pre-evaluation.

Sacramento GMC

- 1.2.2** Revise Plan policy and implement processes so that UM criteria is current, is not stricter than Medi-Cal's for covered services, and is appropriately applied.

San Diego GMC

- 1.2.2** Implement Plan policies to ensure accurate and consistent application of UM criteria.

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- 1.2.3** Implement Plan policies to ensure clear and concise NOA letters that contain accurate information about the Plan's UM decisions.

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1.3

PRIOR AUTHORIZATION APPEAL PROCESS

Appeal Procedures:

There shall be a well-publicized appeals procedure for both providers and Members.
GMC Contract A.5.2.E

SUMMARY OF FINDING(S):

Sacramento GMC

1.3.1 Appeal process

The Plan shall have a well-publicized appeal process for providers and members (*Contract, Exhibit A, Attachment 5 (2) (E)*).

APL 17-006 *Grievance and Appeals Requirements* effective July 1, 2017 defined an appeal as distinct from a grievance with unique reporting and processing requirements. An appeal could be filed in response to any adverse benefit determination.

Plan policy *50-2M Grievance, Initial Determination, and Appeal Process for Resolution of Managed Medi-Cal Member Issues* defined an appeal as a review of an initial adverse decision; it provided appropriate timeframes for appeal submission and resolution, and noted providers could appeal with members' written consent.

The Plan did not have a well-publicized appeal process for providers and members. The Plan did not provide easy to find information that accurately described the appeal process to providers and members.

The *2017 Plan Evidence of Coverage (EOC)* did not explain the appeal process to members or providers:

- The Plan did not describe appeals as different from grievances
- The Plan did not describe appeals as disputes about adverse benefit decisions including UM denials or denials of member requested services (i.e., clinical grievance decisions)
- The Plan did not describe how a member's representative could appeal on their behalf.
- The Plan did not describe the correct timeframes for filing or determining appeals

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The Plan did not provide a member EOC addendum or communicate revised appeal criteria effective July 1, 2017. The Plan submitted a draft EOC with updated appeal information to DHCS July 19, 2018, 43 days before the end of the audit period. Member and provider notice of action letter attachments in a verification study did not contain correct appeal information until June 2018.

The Plan did not have a provider manual. The annual provider letter did not define an appeal as distinct from a grievance and did not describe filing timeframes. The Plan's *HMO Provider Manual* did not define an appeal as distinct from a grievance, or provide timeframes or notification about how to file an appeal on members' behalf. In addition, Plan policy *17.0 Utilization Management Denial of Practitioner Requested Services* "appeal" definition did not match DHCS', and contained outdated information about filing a state fair hearing, part of the appeal process.

In interviews, the Plan confirmed that it did not inform members of revised appeal processes and that it did not have a provider manual.

Without a well-publicized appeal process, the Plan cannot ensure members and providers are aware of and understand a critical process for obtaining health care services. Missed opportunities for filing appeals may result in medically necessary but undelivered services.

San Diego GMC

1.3.1 Appeal Process

The Plan shall have a well-publicized appeal process for providers and members (*Contract, Exhibit A, Attachment 5 (2) (E)*).

APL 17-006 *Grievance and Appeals Requirements* effective July 1, 2017 defined an appeal as distinct from a grievance with unique reporting and processing requirements. An appeal could be filed in response to any adverse benefit determination.

Plan policy *50-2M Grievance, Initial Determination, and Appeal Process for Resolution of Managed Medi-Cal Member Issues* defined an appeal as a review of an initial adverse decision; it provided appropriate timeframes for appeal submission and resolution, and noted providers could appeal with members' written consent.

The Plan did not have a well-publicized appeal process for providers and members. The Plan did not provide easy to find information that accurately described the appeal process to providers and members.

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The *2017 Plan Evidence of Coverage (EOC)* did not explain the appeal process to members or providers:

- The Plan did not describe appeals as different from grievances
- The Plan did not describe appeals as disputes about adverse benefit decisions including UM denials or denials of member requested services (i.e., clinical grievance decisions)
- The Plan did not describe how a member's representative could appeal on their behalf.
- The Plan did not describe the correct timeframes for filing or determining appeals

The Plan did not provide a member EOC addendum or communicate revised appeal criteria effective July 1, 2017. The Plan submitted a draft EOC with updated appeal information to DHCS August 13, 2018, the last month of the audit period.

The Plan did not have a provider manual. Plan policy *SC.RUM.016 Utilization Management Denial of Practitioner Requested Services* contained outdated information about filing a state fair hearing, part of the appeal process.

In interviews, the Plan confirmed that it did not inform members of the revised appeal process and that it did not have a provider manual. The Plan reported that it performed no UM appeals during the audit period.

Without a well-publicized appeal process, the Plan cannot ensure members and providers are aware of and understand a critical procedure for obtaining health care services. Missed opportunities for filing appeals may result in medically necessary but undelivered services.

Sacramento GMC

1.3.2 Appeal Resolution Letters

The Plan shall provide appeal response letters that explain the reasons for its decisions clearly and concisely. The Plan's notice of appeal resolution (NAR) letters shall use the DHCS approved templates (*All Plan Letter 17-006*).

Plan policy *50-2M Grievance, Initial Determination, and Appeal Process for Resolution of Managed Medi-Cal Member Issues* stated its appeal resolution letters described its decisions with clear, concise, and specific language.

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The Plan's appeal resolution letters were not clear and concise, contained inaccuracies, and did not explain why a case did not meet medical necessity. Plan letters did not meet DHCS NAR requirements.

A verification study of three UM appeals showed deficient appeal resolution letters:

- In one case, the Plan upheld the previous denial of a battery for an electronic lift, identifying it as a non-covered luxury item. Though it stated that California Children's Services (CCS) had previously provided the item to the member, it did not explain that she could request a replacement battery from CCS with the Plan's assistance.
- A second letter did not explain how the member did not meet criteria for a portable oxygen concentrator. The letter repeatedly stated the need for further evaluation, and unnecessarily described features of the device the Plan approved instead and those of other available devices.
- A third letter stated the denied item was not medically necessary and explained the Plan's rationale six paragraphs later.
- Resolution letters unnecessarily listed titles of all case reviewers; one letter documented eight individuals.
- None of the letters followed the DHCS-required template, but re-stated the reasons for the initial denial, listed member complaints that accompanied the appeal, and contained the Plan's concerns about not meeting member expectations as in grievance resolutions.

Plan policy *Health Plan Member Services 50-2M, Appendix B, Letters Overview- Complaints and Standard Initial Determinations/Appeals, Section 3* described resolution letter requirements. The policy stated that appeal letters included a grievance resolution if the member had complaints in addition to requesting a reconsideration of the Plan's adverse benefit decision. The policy stated the Plan would distribute NARs to Medi-Cal members in accordance with DHCS and DMHC requirements.

In an interview, the Plan reported that Member Services staff produced NARs, inserting decision makers' clinical rationale into letter templates. Plan letter editors and managers supported Member Services staff in this task. Staff received letter- writing training upon hiring and annually. Member Services routinely evaluated completed NARs.

Unclear and confusing letters about the Plan's healthcare decisions may lead to members making uninformed health care decisions.

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1.3.2 Appeal Resolution Letters

The Plan shall provide appeal response letters that explain the reasons for its decisions clearly and concisely. The Plan's notice of appeal resolution (NAR) letters shall use the DHCS approved templates (*All Plan Letter 17-006*).

Plan policy *50-2M Grievance, Initial Determination, and Appeal Process for Resolution of Managed Medi-Cal Member Issues* stated its appeal resolution letters described its decisions with clear, concise, and specific language.

The Plan's appeal resolution letters were not clear and concise, contained inaccuracies, and did not explain why a case did not meet medical necessity. Plan letters did not meet DHCS NAR requirements.

A verification study of nine appeals resulting from denied member-initiated service requests showed deficient appeal resolution letters:

- In one case, a member appealed a denied payment to a provider for previously approved acupuncture services. The resolution letter did not clearly state a billing error led to the denial letter and that the Plan was not denying payment for the previously approved visits. It did not clearly explain that additional acupuncture visits required another referral. The letter also stated that the member's condition did not require the requested services, which the physician reviewer had not concluded.
- In another case, a member's father appealed the denial of a member requested insulin pump, stating the Plan had not explained what it meant by not medically necessary. The appeal resolution letter again said the pump was not medically necessary without further explanation. In addition, the letter stated that the item was not on the Plan's formulary, leaving unclear whether the denial was for clinical or benefit reasons.
- Eight of nine resolution letters did not follow the DHCS-required template, but re-stated the reasons for the initial denial, listed member complaints that accompanied the appeal, and contained the Plan's concerns about not meeting member expectations as in grievance resolutions.

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Plan policy *Health Plan Member Services 50-2M, Appendix B, Letters Overview-Complaints and Standard Initial Determinations/Appeals, Section 3* described resolution letter requirements. The policy stated that appeal letters included a grievance resolution if the member had complaints in addition to requesting a reconsideration of the Plan's adverse benefit decision. The policy Stated the Plan would distribute NARs to Medi-Cal members in accordance with DHCS and DMHC requirements.

Unclear and confusing letters about the Plan's healthcare decisions may lead to uninformed members making unbeneficial health care decisions.

San Diego GMC

1.3.3 Appeal Decision Makers

The Plan shall ensure the final decision maker of an appeal involving clinical issues is a health care professional qualified to treat the condition or disease that has not participated in any prior decisions related to the appeal (*Contract Exhibit A, Attachment 14, (2) (D) and (G)*).

Plan policy *50-2M Grievance, Initial Determination, and Appeal Process for Resolution of Managed Medi-Cal Member Issues* stated a physician who was not originally involved in the denial of the service reviewed and finally decided all medical necessity appeals.

The Plan allowed the same health care professional who had participated in a prior decision about a denial to decide the appeal of the denial.

In one appeal case, the physician who signed the appeal decision was a decision-maker on the Expedited Review Unit (ERU) committee that considered the member's original service request.

The Plan's *2018 Quality Program Description* stated the Joint Regional Appeals or ERU committees reviewed appeals. Plan policy *50-2M* indicated the ERU committee reviewed all initial determinations and appeals marked urgent and that any participant in a case determination would not join any subsequent decision making about the case. The policy did not describe how the Plan ensured recusal from subsequent decision-making on cases or how multiple physicians resolved an appeal.

Ensuring appeal resolution by a physician not previously involved in the case enhances objective decision-making about health service-requests.

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1.3.4 Appeal decisions

The Plan shall provide or arrange for all medically necessary services required in this Contract. The Plan may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition. The Plan may place appropriate limits on a service based on criteria such as medical necessity, or for utilization control, provided the services furnished can reasonably be expected to achieve their purpose (*Contract Exhibit A, Attachment 10, (1) (A)*).

The Plan shall clearly state the criteria, clinical guidelines, or medical policies used to resolve appeals. (*APL 17-006, Grievance and Appeal Requirements*)

Plan policy *50-2M Grievance, Initial Determination, and Appeal Process for Resolution of Managed Medi-Cal Member Issues* stated the Plan documented clinical reasons, clinical guidelines, medical policies or contract provisions used in adverse medical necessity determinations.

The Plan did not document use of objective criteria, made arbitrary appeal decisions, and upheld the denial of medically necessary services.

A verification study of nine cases showed four appeal decisions that did not meet contractual requirements:

- The Plan upheld denied speech therapy with a specialty group for a member with lung and developmental problems and delayed progress; it referred him to speech therapy at his school, which the member frequently missed, instead of allowing continuation with the provider or arranging for a different specialist. A speech coordinator noted the member had not reached certain goals without citing the source of the guidelines she stated or why they were evidence the services were no longer medically necessary. The Plan terminated medically necessary therapy based on this information and did not furnish alternative services that could reasonably be expected to achieve their purpose.
- The Plan upheld denial of payment for chiropractic services, stating the member did not have subluxation of the spine. The Plan's evidence of coverage (EOC) did not require this diagnosis for approval of these services. The Plan's decision was therefore arbitrary.

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- The Plan upheld the denial of an insulin pump because the member had not controlled her blood glucose. In stating the latter disqualified her from receiving the item without citing objective criteria for that determination (a Plan provider's opinion was the basis for the resolution), the Plan made an arbitrary decision.
- The Plan upheld the denial of additional hospital days for a member who complained of pain, stating she tolerated oral medications, had normal vital signs and was clinically stable without documenting the clinical guidelines used for determining when patients with pain could be discharged. It only used its own provider's assessment of the patient and therefore made an arbitrary decision.
- Decision makers did not document use of clinical guidelines but relied on assessments by Plan specialists consulted during the investigative phase of appeal processing.

Plan policy 50-2M described appeal investigation, including input by clinicians, durable medical equipment (DME), and other service experts, but did not describe the requirement to use evidence-based criteria for all decisions. Appendix B of the Policy documented that a physician could resolve an appeal using professional medical judgement.

When the Plan does not use evidence-based, objective sources for appeal decisions, it may make arbitrary decisions about health service appeals and deny medically necessary services.

RECOMMENDATIONS:

Sacramento GMC and San Diego GMC

- 1.3.1** Revise Plan policies, processes and written materials to ensure the Plan has a well-publicized appeals process for providers and members.
- 1.3.2** Revise Plan policy and processes to ensure appeal letters are clear and concise, explain clinical reasons for medical necessity decisions, and follow the DHCS template.

San Diego GMC

- 1.3.3** Revise and implement Plan processes to ensure physicians who resolve appeals have not participated in prior reviews of the case.
- 1.3.4** Revise Plan policies and processes to ensure appeal decisions are objective, evidence-based and consistent with Medi-Cal guidelines and DHCS requirements.

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CATEGORY 3 – ACCESS AND AVAILABILITY OF CARE

3.1

APPOINTMENT PROCEDURES AND MONITORING WAITING TIMES

Appointment Procedures:

Contractor shall implement and maintain procedures for Members to obtain appointments for routine care, urgent care, routine specialty referral appointments, prenatal care, children's preventive periodic health assessments, and adult initial health assessments. Contractor shall also include procedures for follow-up on missed appointments.

GMC Contract A.9.3.A

Members must be offered appointments within the following timeframes:

- 3) Non-urgent primary care appointments – within ten (10) business days of request;
- 4) Appointment with a specialist – within 15 business days of request;

GMC Contract A.9.4.B.

Prenatal Care:

Contractor shall ensure that the first prenatal visit for a pregnant Member will be available within two (2) weeks upon request.

GMC Contract A.9.3.B

Monitoring of Waiting Times:

Contractor shall develop, implement, and maintain a procedure to monitor waiting times in the providers' offices, telephone calls (to answer and return), and time to obtain various types of appointments...

GMC Contract A.9.3.C

SUMMARY OF FINDING(S):

Sacramento and San Diego GMC

3.1.1 Printed provider directory

A health care service plan shall allow enrollees, potential enrollees, providers, and members of the public to request a printed copy of the provider directory or directories by contacting the plan through the plan's toll-free telephone number, electronically, or in writing. A full service health care service plan shall include all of the following

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information in the provider directory or directories: the provider's name, practice location or locations, and contact information; type of practitioner; National Provider Identifier number; California license number and type of license; area of specialty, including board certification, if any; and identification of providers who no longer accept new patients for some or all of the plan's products (*Health & Safety Code, Section 1367.27(d) and (h)*).

The Plan did not maintain a printed provider directory for members.

The prior two DHCS audits found the Plan utilized a Guidebook as a printed provider directory that did not include Plan-employed physicians and complete information regarding contracted or affiliated providers. The Plan maintained a separate Guidebook for each service area informing members of Plan owned medical centers, medical offices, and specialty facilities, in addition to contracted physicians. Information for contracted providers listed in the Guidebooks did not include the National Provider Identifier number, California license number and type of license, and the ability of the contracted providers to accept new patients. As a corrective action, the Plan developed a draft provider directory, which includes contracted and Plan employed physicians. However, the draft provider directory has not been approved by DHCS as not all the required information is contained in the draft.

The Plan's current Guidebook no longer contains any contracted or Plan-employed physicians; the Guidebook instructs members to go online or contact the Plan's Member Services to find available physicians.

If the Plan does not provide members with a printed provider directory, members without internet access will not be able to find the full network of providers available to them.

This is a repeat finding.

RECOMMENDATION(S):

Sacramento and San Diego GMC

3.1.1 Develop a complete printed provider directory and make it available to members upon request.

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3.3

EMERGENCY SERVICES AND FAMILY PLANNING CLAIMS

Emergency Service Providers (Claims):

Contractor is responsible for coverage and payment of emergency services and must cover and pay for emergency services regardless of whether the provider that furnishes the services has an agreement with the Contractor.

GMC Contract A.8.13

Contractor shall pay for Emergency Services received by a Member from non-contracting providers. Payments to non-contracting providers shall be for the treatment of the Emergency Medical Condition including Medically

Necessary inpatient services rendered to a Member until the Member's condition has stabilized sufficiently to permit referral and transfer in accordance with instructions from Contractor or the Member is stabilized sufficiently to permit discharge....

GMC Contract A.8.13.B.1

At a minimum, Contractor must reimburse the non-contracting emergency department and, if applicable, its affiliated providers for physician services at the lowest level of emergency department evaluation and management CPT (Physician's Current Procedural Terminology) codes, unless a higher level is clearly supported by documentation, and for the facility fee and diagnostic services such as laboratory and radiology.

GMC Contract A.8.13.B.2

For all other non-contracting providers, reimbursement by Contractor, or by a subcontractor who is at risk for out-of-plan emergency services, for properly documented claims for services rendered on or after January 1, 2007 by a non-contracting provider pursuant to this provision shall be made in accordance with Provision 5, Claims Processing, and 42 USC Section 1396u-2(b)(2)(D), and California Welfare and Institutions code Section 14091.3

GMC Contract A.8.13.B.3

Contractor shall cover emergency medical services without prior authorization pursuant to 28 CCR 1300.67(g)(1).

GMC Contract A.9.7.A

Family Planning (Claims):

Contractor shall reimburse non-contracting family planning providers at no less than the appropriate Medi-Cal FFS rate....(as required by Contract)

GMC Contract A.8.9

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3.3

EMERGENCY SERVICES AND FAMILY PLANNING CLAIMS

Claims Processing—Contractor shall pay all claims submitted by contracting Providers in accordance with this section...Contractor shall comply with 42 USC 1396a(a)(37) and Health and Safety Code Sections 1371 through 1371.39.

GMC Contract A.8.5

Time for Reimbursement. A plan and a plan's capitated provider shall reimburse each complete claim, or portion thereof, whether in state or out of state, as soon as practical, but no later than thirty (30) working days after the date of receipt of the complete claim by the plan or the plan's capitated provider, or if the plan is a health maintenance organization, 45 working days after the date of receipt of the complete claim by the plan or the plan's capitated provider, unless the complete claim or portion thereof is contested or denied, as provided in subdivision (h).

CCR, Title 28, Section 1300.71(g)

SUMMARY OF FINDING(S):

Sacramento GMC

3.3.1 Family Planning Claims

The Plan is required to reimburse non-contracting family planning providers at no less than the appropriate Medi-Cal FFS rate (*Contract Exhibit A, Attachment 8 (9)*).

The Plan's *National Claims Administration Medi-Cal Management Guide* stated, Medi-Cal reimburses non-contracted family planning providers at no less than the appropriate Medi-Cal rate.

The Plan paid non-contracted family planning services at less than the Medi-Cal Fee-For-Service rate.

A verification study of 27 family planning claims found 11 claims were not paid at the appropriate Medi-Cal Fee-For-Service rate:

- The Plan's claims processing system paid nine claims at a rate of \$0. The service code J3480, unclassified drugs, was set at a payment rate of \$0 between the months of September 2017 through June 2018.
- Two claims were denied because the service codes, A4267, male condoms, and S4993, contraceptive pills, were not set in the Plan's fee schedule.

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The Plan stated it updated and verified the fee schedule monthly to check for accuracy and completeness; however, the Plan's review did not identify missing service codes or codes set with improper reimbursement rates. The Plan's claims processing system was not configured to pay family planning services at the appropriate non-contracted rates.

Inappropriate denials and reimbursements of family planning claims may limit members' access to care and discourage providers from participating with the health plan if not properly reimbursed.

San Diego GMC

3.3.1 Family Planning Claims

The Plan is required to reimburse non-contracting family planning providers at no less than the appropriate Medi-Cal FFS rate (*Contract Exhibit A, Attachment 8 (9)*).

The Plan shall not improperly deny, adjust or contest a claim (*CCR, Title 28, Section 1300.71(d) (1)*).

The Plan's *National Claims Administration Medi-Cal Management Guide* stated, Medi-Cal reimburses non-contracted family planning providers at no less than the appropriate Medi-Cal rate.

The Plan paid non-contracted family planning services at less than the Medi-Cal Fee-For-Service rate. The Plan misinterpreted a provider's contract and misclassified claims as contracted provider claims instead of non-contracted.

A verification study of 25 family planning claims found 10 claims were not paid at the appropriate Medi-Cal Fee-For-Service rate.

The Plan utilized a state supported services provider contract to adjudicate family planning claims. This process resulted in denial of family planning services that were not included in the contract. Any claims for services other than state supported services should have been treated as non-contracted family planning claims.

Claims processors utilized Plan-created interpretation documents to process claims for contracted providers. The document instructed claims processors to deny services not listed in the document; claims processors were not instructed to pay non-contracted family planning services.

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Inappropriate denials and reimbursements of family planning claims may limit members' access to care and discourage providers from participating with the health plan if not properly reimbursed.

Sacramento GMC

3.3.2 Remittance Advice Denial Reasons

The Plan shall not improperly deny, adjust or contest a claim. For each claim that is either denied, adjusted or contested, the Plan shall provide an accurate and clear written explanation of the specific reasons for the action taken (*CCR, Title 28, Section 1300.71(d) (1)*).

The Plan is required to reimburse each complete claim, or portion thereof, whether in state or out of state as practical, but no later than 45 working days after the date of receipt of the complete claim. The notice that a claim is being contested shall identify the portion of the claim that is contested and the specific reasons for contesting the claim (*H&S Code Section 1371*).

The Plan's *National Claims Administration Medi-Cal Management Guide* states, "A plan or a plan's capitated provider shall not improperly deny, adjust, or contest a claim. For each claim that is either denied, adjusted or contested, the plan or the plan's capitated provider shall provide an accurate and clear written explanation of the specific reasons."

The Plan did not disclose the specific rationale used in determining why claims were rejected.

A verification study of 29 emergency service claims found two claims did not disclose the correct denial rationale; the services were denied as non-covered benefits instead of as other insurance responsibility. In both claims, the Plan was not the primary insurance coverage.

The Plan acknowledged the lack of clarity of the denial rationales stating "the application of this code is programmed within the system to be used when applying a refund received to a claim; after consideration, we will conduct a review of these EOP [Explanation of Payment] reason codes for refunds to improve clarity to our providers."

Disclosing incorrect information on the remittance advice can be misleading and may prevent a provider from resubmitting a claim correctly.

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3.3.2 Remittance Advice Denial Reasons

The Plan is required to comply with Health and Safety Code Section 1371 (*Contract, Exhibit A, Attachment 5 (A)*).

The notice that a claim is being contested shall identify the portion of the claim that is contested and the specific reasons for contesting the claim (*H&S Code Section 1371*).

The Plan shall not improperly deny, adjust or contest a claim. For each claim that is either denied, adjusted or contested, the Plan shall provide an accurate and clear written explanation of the specific reasons for the action taken (*California Code of Regulations, Title 28, Section 1300.71 (d) (1)*).

The Plan's *National Claims Administration Medi-Cal Management Guide* states, "A plan or a plan's capitated provider shall not improperly deny, adjust, or contest a claim. For each claim that is either denied, adjusted or contested, the plan or the plan's capitated provider shall provide an accurate and clear written explanation of the specific reasons."

The Plan did not disclose the specific rationale used in determining why claims were denied.

A verification study of 29 emergency service claims and 25 family planning claims found four claims did not disclose the correct denial rationale. In all four claims, the provider was first paid by the Plan, then by the primary insurance. The provider subsequently reimbursed the Plan. In adjusting the claim, the Plan disclosed the incorrect rationale to the provider:

- Three emergency service claims were denied as non-covered benefits instead of as other insurance responsibility.
- One family planning service was denied as a duplicate payment instead of as other insurance responsibility.

In communications, the Plan acknowledged the lack of clarity of the denial rationales. The Plan stated it would conduct a review of the denial reason codes for refunds to improve clarity to their providers.

Disclosing incorrect information on the remittance advice may prevent providers from submitting claims correctly.

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PLAN: KP Cal, LLC – Kaiser Permanente Sacramento and San Diego GMC
AUDIT PERIOD: September 1, 2017 to August 31, 2018 DATE OF AUDIT: October 1, 2018 to October 12, 2018

RECOMMENDATION(S):

Sacramento and San Diego GMC

- 3.3.1** Develop and implement procedures to ensure appropriate adjudication of non-contracted family planning claims.
- 3.3.2** Implement policies and procedures and configure claims system to disclose the specific rationale used in determining why the claim was rejected.

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CATEGORY 4 – MEMBER’S RIGHTS

4.1

GRIEVANCE SYSTEM

Member Grievance System and Oversight:

Contractor shall implement and maintain a Member Grievance System in accordance with 28 CCR 1300.68 (except Subdivision 1300.68(g).), and 1300.68.01, 22 CCR Section 53858, Exhibit A, Attachment 13, Provision 4, Subprovision D, item 12), and 42 CFR 438.420(a)-(c).

GMC Contract A.14.1

Contractor shall implement and maintain procedures...to monitor the Member’s grievance system and the expedited review of grievances required under Title 28, CCR, Sections 1300.68 and 1300.68.01 and Title 22 CCR Section 53858....(as required by Contract)

GMC Contract A.14.2

Contractor shall maintain, and have available for DHCS review, grievance logs, including copies of grievance logs of any subcontracting entity delegated the responsibility to maintain and resolve grievances. Grievance logs shall include all the required information set forth in Title 22 CCR Section 53858(e).

GMC Contract A.14.3.A

SUMMARY OF FINDING(S):

Sacramento GMC

4.1.1 Grievance Resolution

The Plan shall resolve grievances as described in 28 CCR 1300.68 (*Contract, Exhibit A, Attachment 14 (1)*).

A grievance is an expression of dissatisfaction. The Plan shall resolve grievances within 30 calendar days of receipt, where resolved means the Plan has reached a conclusion with respect to the enrollee’s submitted grievance (*CCR, Title 28, Section 1300.68*).

The Plan shall address and resolve all issues presented in a member grievance (*APL 17-006, (VII) (E)*).

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Plan policy *50-2M Grievance, Initial Determination and Appeal Process for Resolution of Managed Medi-Cal Member Issues* stated, to the extent possible, the Plan facilitates a complete resolution to the member's concern and/or requests. Member services directed potential quality of care grievances to the Medical Director for review and decisions.

The Plan closed cases without addressing and resolving all issues in a member's grievance. The Plan did not investigate or only partially investigated and resolved grievances.

A verification study of 32 grievances revealed deficiencies in 15 cases:

- The Plan did not investigate five grievances that alleged improper treatment and sent resolution letters closing the cases; members had stated they did not wish to be contacted after filing the grievances. In one case, a member complained a pharmacy technician handed her another member's medications and was unprofessional and uncooperative when advised of the error. Documentation did not show the Plan attempted to identify the member whose medications were dispensed in error, which pharmacy technician was involved, or how the error occurred. The Plan forwarded the complaint to the Pharmacy department and sent a member resolution letter that did not describe any investigative efforts.
- In a sixth case, the Plan did not investigate a second grievance that followed the unsatisfactory resolution of the member's first complaint.
- In six additional cases, when grievances combined member service requests with complaints about care, the Plan approved or denied the service, but did not completely resolve the other issues. For example, the Plan did not investigate a mother's allegation of provider discrimination due to the member's race and Medi-Cal coverage.

Plan policy *50-2M* stated an Investigative Review (IR) or For Your Information/Action (FYI/A) form notified supervisory staff about a grievance when the member requested no information or when the Plan did not require additional information.

In an interview, the Plan stated it resolved non-clinical grievances by considering the member's perspective, and did not require input from involved staff. If a member stated they did not require follow-up after submitting a grievance, the Plan did not conduct a grievance investigation. The Plan asserted that all clinical grievances received a physician review; it considered grievances that combined complaints with member service requests resolved when it approved or denied the service. Both processes showed an incomplete grievance resolution process.

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Incomplete resolution of member grievances may result in missed opportunities for improved health care delivery and in poor health outcomes for members.

San Diego GMC

4.1.1. Grievance Resolution

The Plan shall resolve grievances as described in 28 CCR 1300.68 (*Contract, Exhibit A, Attachment 14 (1)*).

A grievance is an expression of dissatisfaction. The Plan shall resolve grievances within 30 calendar days of receipt, where resolved means the Plan has reached a conclusion with respect to the enrollee's submitted grievance (*CCR, Title 28, Section 1300.68*).

The Plan shall address and resolve all issues presented in a member grievance (*APL 17-006, (VII) (E)*).

Plan policy *50-2M Grievance, Initial Determination and Appeal Process for Resolution of Managed Medi-Cal Member Issues* stated, to the extent possible, the Plan facilitates a complete resolution to the member's concern and/or requests. Member services directed potential quality of care grievances to the Medical Director for review and decisions.

The Plan closed cases without addressing and resolving all issues presented in a member's grievance. The Plan only partially investigated and resolved grievances.

A verification study of 15 clinical grievances revealed processing deficiencies in five cases:

- In one case, the member complained the Plan would not provide regularly scheduled therapy visits on preferred days of the week; he was willing to travel to other Plan medical centers besides his own. He complained about waiting weeks for therapy visits and that Plan staff provided conflicting information about his mental health benefits. He had not received an Evidence of Coverage (EOC) from the Plan explaining his benefits.
 - After investigation, the Plan denied the request for therapy at preferred times.
 - Documentation did not show the Plan investigated availability of appointments at other facilities or the member's complaint about delayed appointments.
 - The Plan did not investigate the member's complaints of conflicting information by member services staff.

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- In four cases, the Plan did not ask providers for input when members complained about their behavior; investigation consisted of medical record review. For example, a member's father complained: He requested a tubeless insulin pump and a new physician for his daughter. He reported her physician said the device was denied. The father found the provider had not requested the item when he called the DME provider. The Plan confirmed the provider had not requested the device but did not ask him to address allegations of a misstatement to a member.

Plan policy 50-2M described the grievance review process. Member services staff directed potential quality of care grievances to the Medical Director for review and decisions. The Plan used an Investigative Review form to obtain input from staff not involved in the grievance. Sometimes, the Plan asked the subject of a grievance for their input. The Plan's goal was a comprehensive resolution of the member's concern(s) and/or request(s).

In an interview, the Plan asserted that all clinical grievances received a physician review. The Plan considered grievances that combined complaints with member service requests resolved when it approved or denied the service. If a member stated they did not require a call back after submitting a grievance, the Plan did not conduct a grievance investigation. Both processes showed an incomplete grievance resolution process.

Incomplete resolution of member grievances may result in missed opportunities for improved health care delivery and in poor health outcomes for members.

Sacramento GMC

4.1.2 Grievance Resolution letters

The Plan shall implement and maintain a grievance system as described in 28 CCR 1300.68 (*Contract, Exhibit A, Attachment 14 (1) (A)*).

The Plan's written resolution to the member shall contain a clear and concise explanation of its decision (*28 CCR, 1300.68; APL 17-006 (III) (C) (2)*).

Plan policy *Health Plan Member Services 50-2M Grievance, Initial Determination and Appeal Process for Resolution of Managed Medi-Cal Member Issues* stated resolution letters contained clear and concise explanations of the Plan's grievance decision.

The Plan sent grievance resolution letters without clear and concise descriptions of the Plan's decisions, and sent letters with inaccurate statements.

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A verification study of 12 clinical grievances revealed four deficient grievance resolution letters:

- The Plan did not review a grievance dated March 2017 because the member did not give written permission for his wife to represent him. The Quality department conducted and closed a separate investigation of the matter in June 2017. The member gave written permission for his wife to represent him in December 2017. The resolution letter of January 2018 stated the Plan would investigate his grievance, but it did not.
- In two cases, members requested services as part of their grievances. The Plan did not explain the clinical rationale for denying the members' requests.
- In an additional case, the grievance resolution contained all of the physician reviewer's internal notes and was not clear and concise.

Plan policy *50-2M, Appendix B, Letters Overview-Complaints and Standard Initial Determinations/Appeals*, described resolution letter requirements. These included clear and concise language and a 6th grade reading level. For medical necessity denial letters, letters contained the criteria, guidelines or protocols used and clinical reasons for the determination. The policy said, "It is not sufficient to say the requested service is "not medically necessary."

Unclear and confusing letters about the Plan's healthcare decisions may lead to uninformed members making unbeneficial health care decisions.

San Diego GMC

4.1.2 Grievance Resolution letters

The Plan shall implement and maintain a grievance system as described in 28 CCR 1300.68 (*Contract, Exhibit A, Attachment 14 (1) (A)*).

The Plan's written resolution to the member shall contain a clear and concise explanation of its decision (*28 CCR, 1300.68; APL 17-006 (III) (C) (2)*).

Plan policy *Health Plan Member Services 50-2M Grievance, Initial Determination and Appeal Process for Resolution of Managed Medi-Cal Member Issues* stated resolution letters contained clear and concise explanations of the Plan's grievance decision.

The Plan sent grievance resolution letters without clear and concise descriptions of the Plan's decisions or letters with inaccurate statements.

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A verification study of 15 clinical grievances revealed 13 deficient grievance resolution letters:

- Letters contained misstatements and errors.
 - A letter contained the following passage: “You can submit the Dental Anesthesia Request Form to the dentist/oral surgeon and submit directly to the Outside Referrals Department to have them medically review to see if [redacted] meets the Kaiser Permanente does not cover the fees of the dental surgeon.”
 - Another letter stated, “The Chief of Service of the Pediatrics Departments shared on March 20, 2018, that [redacted] has a slight to normal shape. She said that during his second opinion visit with the Plastic Surgery Department on March 19, 2018, the doctor talked about the role back of a sleep program. It was noted that the factor to a rounder head shape can also come from parents’ physical characteristics.”
 - Another letter addressed to a female member contained the name of a male member.
- Two letters stated that requested services were not medically necessary without explaining why. In one of two cases, the member’s father subsequently appealed the decision stating the Plan did not provide a thorough explanation for the denial.
- Four letters contained unnecessary information, making them unclear and unconcise. For example, one letter contained a restatement of a surgeon’s opinion about the case and a denial of the request without explaining how the Plan resolved the member’s problem. Two of the letters contained long lists of all medical reviewers.

Plan policy *50-2M, Appendix B, Letters Overview-Complaints and Standard Initial Determinations/Appeals*, described resolution letter requirements. These included clear and concise language and a 6th grade reading level. For medical necessity denial letters, letters contained the criteria, guidelines or protocols used and clinical reasons for the determination. The policy said, “It is not sufficient to say the requested service is “not medically necessary.”

Unclear and confusing letters about the Plan’s healthcare decisions may lead to uninformed members making unbeneficial health care decisions.

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4.1.3 Grievance reporting

The Plan shall implement and maintain a grievance system as described in 28 CCR 1300.68 (*Contract, Exhibit A, Attachment 14 (1) (A)*).

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The Plan shall ensure “The written record of grievances shall be reviewed periodically by the governing body of the plan, and by an officer of the plan or his designee. This review shall be thoroughly documented” (*CCR, Title 28, Section 1300.68*).

Plan policy *CA.SCQC.QOC.004 KFHP Regional Quality Management Reporting Policy NCAL/SCAL* stated, “The KFHP Board, by its Quality Health Improvement Committee (QHIC) requires specified quality metrics to be reported to the regional quality oversight committee. Additional specific reports will include: Twice a year, regional reports of complaint data including significant complaint patterns and trends related to quality issues, previously reviewed by regional quality oversight committees.”

The Plan did not document periodic review of GMC Medi-Cal Managed Care grievances by the Quality and Health Improvement Committee (QHIC).

Redacted QHIC meeting minutes for July 2018 did not contain GMC Sacramento grievance data. Additional reports to the QHIC did not include Medi-Cal grievance data. The Plan provided only one set of QHIC meeting minutes.

In interviews, the Plan reported it did not traditionally separate Medi-Cal grievance data from other lines of business.

Without regular grievance reports, the Board of Directors does not have all the information it needs for effective oversight of Medi-Cal members’ health care delivery.

Sacramento GMC

4.1.4 Member-requested services.

The Plan shall provide or arrange for members all medically necessary and other services required in this contract and ensure it provides services in an amount no less than that offered to Medi-Cal Fee-For-Service beneficiaries (*Contract, Exhibit A, Attachment 10 (1) (A)*).

The Plan may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition. It may use criteria such as medical necessity to limit services in an appropriate manner provided the services allowed can be reasonably expected to achieve their purpose (*Contract, Exhibit A, Attachment 10 (1) (B)*).

The contract states “medically necessary” means all covered services reasonable and necessary to protect life, prevent significant illness or significant disability, or to alleviate severe pain through diagnosis or treatment” (*Contract, Exhibit A, Attachment 10 (2)*).

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Plan policy *50-2M Grievance, Initial Determination, and Appeal Process for Resolution of Managed Medi-Cal Member Issues* defined initial determinations as member requests for services submitted as part of an expression of dissatisfaction. It stated the Plan described the criteria, the clinical reasons, medical policies, or clinical judgment used for any denials of member requested services.

The Plan arbitrarily denied medically-necessary services requested through the grievance process.

A verification study of 12 grievances included seven initial determinations; three of the seven requests revealed deficiencies in processing the cases:

- A member requested Botox for intractable migraines. The physician reviewer stated the drug was not medically indicated, did not describe the clinical reasons for his decision, and denied the request.
- A member with a history of liver cancer complained she had abdominal pain and her physician would not order an abdominal ultrasound. The physician reviewer denied the ultrasound stating the test could be ordered, but would be denied because the member had not allowed a physical examination. The reviewer did not provide clinical criteria or guidelines for his decision.
- A member with a genetic disorder (osteogenesis imperfecta, or OI) leading to easily broken bones filed a grievance with multiple complaints, and requested an Orthopedics referral. The physician reviewer denied the referral due to no prior treatment of her complaints, no fractures on x-ray, and the member's chronic pain, opioid dependence and mental health issues. Though Orthopedists treat OI, the reviewer did not show the guidelines he used for his denial or how the member did not meet them.

Plan policy *50-2M* indicated members could request services through the grievance process. The policy stated physician reviewers could use clinical judgement to decide the outcome of the requests. Members received written notification of the decisions and appeal rights.

In interviews, the Plan stated it began reviewing member requested services through the grievance process after Department of Managed Health Care (DMHC) survey findings that raised concerns about the Plan's UM processes. The Plan noted that service requests initiated by members through the grievance process did not require the application of approved, written, evidence based criteria for determination because the requests were for services that did not require PA, and were for items a provider could

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or could not order based on their own judgement. The Plan reported that physician reviewers of initial determinations were providers in leadership positions who exercised appropriate clinical judgement in determining the medical necessity of member requests.

When the Plan does not use objective criteria for its service delivery decisions, it may deny medically necessary services for members.

San Diego GMC

4.1.4 Member-requested services

The Plan shall provide or arrange for members all medically necessary and other services required in this contract and ensure it provides services in an amount no less than that offered to Medi-Cal Fee-For-Service beneficiaries (*Contract, Exhibit A, Attachment 10 (1) (A)*).

The Plan may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition. It may use criteria such as medical necessity to limit services in an appropriate manner provided the services allowed can be reasonably expected to achieve their purpose (*Contract, Exhibit A, Attachment 10 (1) (B)*).

The Plan shall cover out-of-network (OON) services when it cannot provide covered services within Plan (*Contract, Exhibit A, Attachment 9 (17)*).

The Plan shall provide services for Medi-Cal beneficiaries under the age of twenty-one and ensure they receive appropriate preventive, dental, mental health, developmental, and specialty services (*Contract, Exhibit A, Attachment 10 (5); APLs 14-017 and 18-007*).

Plan policy *50-2M Grievance, Initial Determination, and Appeal Process for Resolution of Managed Medi-Cal Member Issues* defined initial determinations as member requests for services submitted as part of an expression of dissatisfaction. It stated the Plan described the criteria, the clinical reasons, medical policies, or clinical judgment used for any denials of member requested services.

The Plan denied clinical services members requested without documenting it used established, evidence-based criteria for its decisions. Services included those for which evidence based criteria existed.

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A verification study of 15 grievances, all of which included a request for a service, revealed deficiencies in processing five member service requests:

- In one case, a member's mother complained that his previously approved speech therapy services were to be terminated. She requested continuation of therapy. The Plan denied the request based on a speech therapy coordinator's assessment the member had progressed little and could obtain therapy in school, and did not cite the source of the coordinator's guidelines. The Plan did not show how it would meet the contract's requirement to provide effective therapy for the member.
- The Plan denied previously approved behavioral health treatment (BHT) for an autistic member. The provider could no longer treat the member due to injurious behaviors. The Plan did not cite the BHT criteria it used for its denial. The Plan did not show how it would meet the contract's requirement to provide effective therapy for the member.
- In two cases, one a request for an insulin pump and the other for continued hospitalization, the Plan did not cite the established criteria it used for its denials.

Plan policy *50-2M* indicated members could request services through the grievance process. The policy stated physician reviewers could use clinical judgement to decide the outcome of the requests. Members received written notification of the decisions and appeal rights.

In interviews, the Plan stated it began reviewing member requested services through the grievance process after Department of Managed Health Care (DMHC) survey findings that raised concerns about the Plan's UM Processes. The Plan noted that service requests initiated by members through the grievance process did not require the application of approved, written, evidence based criteria for determination because the requests were not submitted through the PA process. The Plan reported that physician reviewers of initial determinations were providers in leadership positions who exercised appropriate clinical judgement in determining the medical necessity of member requests.

When the Plan does not use objective criteria for its service delivery decisions, it may deny medically necessary services to members.

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4.1.5 Grievance classification

The Plan shall ensure the grievance submitted is reported to an appropriate level, i.e., medical issues versus health care delivery issues, and that the person making the final decision for the proposed resolution of a grievance is a health care professional with clinical expertise in treating a member's condition for any grievance involving clinical issues (*Contract, Exhibit A, Attachment 14 (2) (G)*).

Plan policy *50-2M Grievance, Initial Determination, and Appeal Process for Resolution of Managed Medi-Cal Member Issues* stated appropriate managers reviewed grievances and initial determination requests. At least one practitioner practicing of the same or a similar specialty reviewed clinical issues.

The Plan did not ensure that it reported grievances to an appropriate level. The Plan classified grievances with clinical issues as service-related and did not ensure a qualified health care professional made a final decision about or resolved the members' grievances.

The Plan listed grievances received during the audit period in a grid under category types access, benefit/coverage, medical necessity, other, quality of care, and quality of service.

A verification study showed the Plan classified 13 of 20 grievances as QOS or benefit/coverage grievances though they contained complaints related to denied services, misdiagnosed conditions, and inappropriate medical care:

- Nine of the 13 cases showed identification of clinical elements and resolution by clinicians in spite of misclassification.
- Four of the 13 cases showed a healthcare professional qualified to treat disease did not resolve the grievances.
 - One of the four complained of delayed prescription filling that lead to a missed dose of a medication.
 - Another alleged discrimination by the member's provider and lack of care. An FYI notice was sent to a physician who did not enter a note of resolution in the case.
 - Another of the four cases alleged inappropriate touching by technical staff performing an electrocardiogram. An FYI notice was sent to the director of cardiology who was not identified as a physician in the file and who did not resolve the case.

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- In the fourth case, the member complained of falling down stairs at the medical facility. Registered Nurse case review showed the member fainted while on her way to the lab after seeing her doctor. No MD reviewed the chart though investigation showed the member had a history of dizziness.

Plan policy 50-2M stated Member Services processed grievances (complaints) and a program representative forwarded them to the appropriate processing unit. The policy stated, “KFHP categorizes Grievances into three case types: Complaints, Initial Determinations, and Appeals.” It did not describe how member services or other staff decide to categorize a case as service related or clinical.

Classification of clinical grievances as quality of service cases may result in overlooked clinical problems and missed opportunities for healthcare system improvements.

San Diego GMC

4.1.5 Grievance classification

The Plan shall ensure the grievance submitted is reported to an appropriate level, i.e., medical issues versus health care delivery issues, and that the person making the final decision for the proposed resolution of a grievance is a health care professional with clinical expertise in treating a member’s condition for any grievance involving clinical issues (*Contract, Exhibit A, Attachment 14 (2) (G)*).

Plan policy 50-2M *Grievance, Initial Determination, and Appeal Process for Resolution of Managed Medi-Cal Member Issues* stated appropriate managers reviewed grievances and initial determination requests. At least one practitioner practicing of the same or a similar specialty reviewed clinical issues.

The Plan did not ensure that it reported grievances to an appropriate level. The Plan classified clinical grievances as quality of service (QOS) reviews or benefits cases and did not ensure a qualified health care professional made a final decision about or resolved members’ clinical grievances.

The Plan listed grievances received during the audit period in a grid under category types access, benefit/coverage, medical necessity, other, quality of care, and quality of service.

A verification study showed the Plan labeled 11 of 19 grievances as benefit or QOS grievances though they contained clinical components such as requests for services and alleged mishandled care:

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- Five of the 11 cases showed identification of clinical elements and resolution by clinicians in spite of misclassification.
- Six of the 11 cases did not receive grievance resolutions by healthcare professionals qualified to treat the condition.
 - In one of the six cases, an MD did not review a grievance that complained the member's asthma worsened because she could not easily contact her doctor. By the time the member saw the doctor, the provider was concerned for pneumonia.
 - In one case, a non-physician ER manager reviewed the member's complaint of a long wait time; the grievance investigation did not include an MD review though the member complained of unbearable pain and an inappropriate exam.
 - In two of the 11 cases, members complained of inadequate care by psychiatric providers
 - In one case, the Department of Managed Health Care returned a grievance to the Plan for issues/requests not previously addressed. The member had filed an earlier grievance alleging discrimination and being refused needed medications.
 - In a sixth case, the member refused a planned treatment due to discomfort with the nursing staff.
 - In the above six cases, the Plan sent FYI notices to physicians who did not enter a note of resolution in the case.

Plan policy 50-2M stated Member Services processed grievances (complaints) and a program representative forwarded them to the appropriate processing unit. The policy stated, "KFHP categorizes Grievances into three case types: Complaints, Initial Determinations, and Appeals." It did not describe how member services or other staff decide to categorize a case as service related or clinical.

Classification of clinical grievances as quality of service cases may result in overlooked clinical problems and missed opportunities for healthcare system improvements.

RECOMMENDATION(S):

Sacramento and San Diego GMC

- 4.1.1** Revise and implement Plan policies and processes to ensure complete investigation and resolution of member's grievances.
- 4.1.2** Revise Plan processes to ensure members receive clear and concise grievance resolution letters.
- 4.1.3** Revise and implement Plan policies and processes to document review of GMC grievance data by the Plan's Board and the frequency of that reporting.

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PLAN: KP Cal, LLC – Kaiser Permanente Sacramento and San Diego GMC
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Sacramento GMC

- 4.1.4** Revise and implement Plan policies and processes to ensure member service requests are determined using objective and contractually required guidelines.

San Diego GMC

- 4.1.4** Revise and implement Plan policies and processes to ensure member service requests are determined using objective, evidence-based and contractually required guidelines.

Sacramento and San Diego GMC

- 4.1.5** Revise and implement Plan policies and processes to ensure appropriate classification and resolution of grievances with clinical content by qualified health care professionals.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: KP Cal, LLC – Kaiser Permanente Sacramento and San Diego GMC

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4.3

CONFIDENTIALITY RIGHTS

Health Insurance Portability and Accountability Act (HIPAA) Responsibilities:

Business Associate agrees:

Safeguards. To implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the PHI, including electronic PHI, that it creates, receives, maintains, uses or transmits on behalf of DHCS, in compliance with 45 CFR sections 164.308, 164.310 and 164.312, and to prevent use or disclosure of PHI other than as provided for by this Agreement. Business Associate shall implement reasonable and appropriate policies and procedures to comply with the standards, implementation specifications and other requirements of 45 CFR section 164, subpart C, in compliance with 45 CFR section 164.316....

GMC Contract G.III.C.2

Breaches and Security Incidents. During the term of this Agreement, Business Associate agrees to implement reasonable systems for the discovery and prompt reporting of any breach or security incident, and to take the following steps:

1. **Notice to DHCS.** (1) To notify DHCS **immediately by telephone call plus email or fax** upon the discovery of a breach of unsecured PHI or PI in electronic media or in any other media if the PHI or PI was, or is reasonably believed to have been, accessed or acquired by an unauthorized person, or upon the discovery of a suspected security incident that involves data provided to DHCS by the Social Security Administration. (2) To notify DHCS **within 24 hours by email or fax** of the discovery of any suspected security incident, intrusion or unauthorized access, use or disclosure of PHI or PI in violation of this Agreement and this Addendum, or potential loss of confidential data affecting this Agreement. A breach shall be treated as discovered by Business Associate as of the first day on which the breach is known, or by exercising reasonable diligence would have been known, to any person (other than the person committing the breach) who is an employee, officer or other agent of Business Associate.
2. **Investigation and Investigation Report.** To immediately investigate such security incident, breach, or unauthorized access, use or disclosure of PHI or PI. Within 72 hours of the discovery, Business Associate shall submit an updated "DHCS Privacy Incident Report" containing the information ...to the extent known at that time, to the DHCS Program Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer:

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

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4.3

CONFIDENTIALITY RIGHTS

3. **Complete Report.** To provide a complete report of the investigation to the DHCS Program Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer within ten (10) working days of the discovery of the breach or unauthorized use or disclosure.

GMC Contract G.III.J

Sacramento GMC

4.3.1 72-hour Reporting Timeframe

The Plan is required to immediately investigate each security incident, breach, or unauthorized use or disclosure of protected health information (PHI) or confidential data. Within 72 hours of the discovery, the Plan shall notify the DHCS MMCD Contracting Officer, the SDHCS Privacy Officer, and the DHCS Information Security Officer (*Contract, Exhibit G, (3) (H) (2)*).

Plan Policy *NCAL-PRIV/SEC-025 Breach Notification Procedures* stated for security incidents or unauthorized use of PHI involving Medi-Cal members, within 72 hours of the discovery, the Plan shall submit an updated “DHCS Privacy Incident Report” containing the information marked with an asterisk and all other applicable information listed on the form, to the extent known at the time, to the DHCS Program Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer.

The Plan did not notify DHCS of suspected security incidents and unauthorized use of PHI within 72 hours of the discovery.

A verification study of 12 cases revealed seven security incident cases and one unauthorized PHI case where the DHCS Privacy Incident Report was not provided to all required personnel within 72 hours.

The Plan stated that four of the cases identified fell outside the 72-hour timeframes due to an inadvertent error in their excel worksheet used to track reporting deadlines.

The Plan stated four other cases exceeded 72 hours because it did not consider weekend and holiday hours as part of the contractually required timeframe.

By not reporting suspected security incidents and unauthorized use of PHI or confidential data within required timeframes, the Plan is out of compliance with the contract.

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San Diego GMC

4.3.1 72-hour Reporting Timeframe

The Plan is required to immediately investigate each security incident, breach, or unauthorized use of disclosure of protected health information (PHI) or confidential data. Within 72 hours of the discovery, the Plan shall notify the DHCS MMCD Contracting Officer, the SDHCS Privacy Officer, and the DHCS Information Security Officer (*Contract, Exhibit G, (3) (H) (2)*).

Plan Policy SC.RCO.PS.025 stated for security incidents or unauthorized use of PHI involving Medi-Cal members, within 72 hours of the discovery, the Plan shall submit an updated "DHCS Privacy Incident Report" containing the information marked with an asterisk and all other applicable information listed on the form, to the extent known at the time, to the DHCS Program Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer.

The Plan did not notify DHCS of suspected security incidents and unauthorized use of PHI within 72 hours of the discovery.

A verification study of five cases revealed one security incident case and two unauthorized PHI cases where the DHCS Privacy Incident Report was not provided to all required personnel within 72 hours.

The Plan stated the cases exceeded 72 hours because it did not consider weekend and holiday hours as part of the contractually required timeframe.

By not reporting suspected security incidents and unauthorized use of PHI or confidential data within required timeframes, the Plan is out of compliance with the contract.

RECOMMENDATION(S):

Sacramento and San Diego GMC

4.3.1 Implement policies and procedures to ensure the Plan notifies DHCS of suspected security incidents and unauthorized use of PHI or confidential data within 72-hours of discovery.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: KP Cal, LLC – Kaiser Permanente Sacramento and San Diego GMC

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CATEGORY 5 – QUALITY MANAGEMENT

5.1

QUALITY IMPROVEMENT SYSTEM/ DELEGATION OF QUALITY IMPROVEMENT ACTIVITIES

General Requirements:

Contractor shall implement an effective Quality Improvement System (QIS) in accordance with the standards in Title 28, CCR, Section 1300.70. Contractor shall monitor, evaluate, and take effective action to address any needed improvements in the quality of care delivered by all providers rendering services on its behalf, in any setting. Contractor shall be accountable for the quality of all Covered Services regardless of the number of contracting and subcontracting layers between Contractor and the provider.

GMC Contract A.4.1

Written Description: Contractor shall implement and maintain a written description of its QIS [Quality Improvement System]...(as required by Contract)

GMC Contract A.4.7.A-I

Accountability: Contractor shall maintain a system of accountability which includes the participation of the governing body of the Contractor's organization, the designation of a quality improvement committee with oversight and performance responsibility, the supervision of activities by the medical director, and the inclusion of contracted physicians and contracted providers in the process of QIS development and performance review....

GMC Contract A.4.2

Governing Body: Contractor shall implement and maintain policies that specify the responsibilities of the governing body...(as required by Contract)

GMC Contract A.4.3.A-D

Provider Participation: Contractor shall ensure that contracting physicians and other providers from the community shall be involved as an integral part of the QIS. Contractor shall maintain and implement appropriate procedures to keep contracting providers informed of the written QIS, its activities, and outcomes.

GMC Contract A.4.5

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

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5.1

QUALITY IMPROVEMENT SYSTEM/ DELEGATION OF QUALITY IMPROVEMENT ACTIVITIES

Delegation of Quality Improvement Activities:

- A. Contractor is accountable for all quality improvement functions and responsibilities (e.g. Utilization Management, Credentialing and Site Review) that are delegated to subcontractors. If Contractor delegates quality improvement functions, Contractor and delegated entity (subcontractor) shall include in their Subcontract, at minimum:
 - 1) Quality improvement responsibilities, and specific delegated functions and activities of the Contractor and subcontractor.
 - 2) Contractor's oversight, monitoring, and evaluation processes and subcontractor's agreement to such processes.
 - 3) Contractor's reporting requirements and approval processes. The agreement shall include subcontractor's responsibility to report findings and actions taken as a result of the quality improvement activities at least quarterly.
 - 4) Contractor's actions/remedies if subcontractor's obligations are not met.

- B. Contractor shall maintain a system to ensure accountability for delegated quality improvement activities, that at a minimum:
 - 1) Evaluates subcontractor's ability to perform the delegated activities including an initial review to assure that the subcontractor has the administrative capacity, task experience, and budgetary resources to fulfill its responsibilities.
 - 2) Ensures subcontractor meets standards set forth by the Contractor and DHCS.
 - 3) Includes the continuous monitoring, evaluation and approval of the delegated functions.

GMC Contract A.4.6

SUMMARY OF FINDING(S):

Sacramento GMC

5.1.1 Quality Improvement Committee Reporting

The Plan shall ensure that this contract is a high priority (*Contract, Exhibit A, Attachment 1, (4) (B)*).

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The Plan shall implement policies that, at a minimum, state the governing body will routinely receive written progress reports from the quality improvement (QI) committee describing actions taken, progress in meeting QIS objectives, and improvements made (*Contract, Exhibit A, Attachment 4, (3) (C)*).

KFHP's Quality Improvement (QI) Work Plan described the Geographic Managed Care (GMC) department and GMC Medi-Cal QOC as the entities accountable for GMC Medi-Cal managed care quality issues. The GMC QOC charter described the committee's authority to implement and oversee the quality program for Plan members covered by the contract.

Neither KP Cal, LLC nor the KFHP governing body documentation showed routine receipt of GMC QOC quality reports. Plan policies did not state the governing body would routinely receive Medi-Cal quality reports from the GMC QOC.

The GMC QOC charter stated the committee reported quarterly to local oversight committees, and to the KP Cal, LLC. Board and regional QOC annually. The QI program description did not state how the GMC QOC reported to the governing body.

Infrequent reporting between the accountable quality committee and the governing body reflects noncompliant processes that may result in missed opportunities to improve quality of care and services for Medi-Cal members.

Sacramento GMC

5.1.2 Quality Improvement System (QIS) Written Description

The Plan's written description of its QIS shall include an organizational chart showing key staff and committees responsible for quality improvement activities including reporting relationships. It shall describe the role, structure, and function of the quality improvement committee (*Contract, Exhibit A, Attachment 4 (7) (B)*).

KFHP's Quality Improvement (QI) Work Plan described the Geographic Managed Care (GMC) department and GMC Medi-Cal QOC as the entities accountable for GMC Medi-Cal managed care quality issues. The GMC QOC charter described the committee's authority to implement and oversee the quality program for Plan members covered by the contract.

KFHP's quality organizational chart did not include the GMC QOC or entities that reported to the committee on Medi-Cal quality matters. KFHP's Quality Program Description (QPD) did not describe the GMC QOC, its role in the quality program, or its reporting relationship to its board.

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The GMC QOC was accountable for the full scope of the Medi-Cal quality program. Duties included, but were not limited to, evaluating all clinical care and services, preparing quality data, approving quality improvement actions, monitoring Medi-Cal members' service utilization, evaluating quality initiative projects, and communicating quality actions, conclusions and priorities to leaders and stakeholders.

Organizational charts did not list the committee or its reporting relationships. The QPD did not describe the committee though it implemented the Medi-Cal quality program.

Without accurate organizational charts and inclusion of an essential committee in its QPD, the Plan cannot demonstrate how it reported and monitored Medi-Cal quality information. This may adversely affect delivery of quality care to Medi-Cal members.

Sacramento GMC

5.1.3 Potential Quality Incidents (PQIs)

The Plan shall monitor, evaluate, and take effective action to address any needed improvements in the quality of care delivered by all providers rendering services on its behalf, in any setting (*Contract, Exhibit A, Attachment 4 (1)*).

Plan policy *CA.SCQC.QOC.005 Monitoring and Assessments of Quality Processes* stated the Plan continually assessed and improved the quality of care through a comprehensive and effective quality program.

The Plan did not take effective action to address needed improvements in the quality of care when it did not require action after potential quality incident (PQI) investigations revealed issues in pain reporting and discharge processes.

A verification study revealed PQI process deficiencies in two of five cases:

- A quality investigation showed staff did not document a member's anesthesia-related corneal abrasion and severe eye pain before discharge. The member required return visits for treatment.
- Another PQI showed a hospital physician did not inform a member's treating doctor he was releasing the patient before completing planned treatment for a severe gastrointestinal problem; staff did not document the member's continued pain at discharge. The member required re-hospitalization.
- In both cases, the Plan determined there was no system error (S0; no action required) and discussed pain documentation errors with involved staff.

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Plan policy *CA.SCQC.QOC.005* and PQI cases outlined the Plan's quality investigation oversight. Policy *NATL.DCSQ.002 Peer Review and Evaluation of Licensed Independent Practitioner Performance* described severity level assignment after case investigation and peer review. All cases received a review for potential systems issues. The Quality department trended systems issues labeled S1 (potential or minor opportunity to improve system.)

In an interview, the Plan noted that it had an established pain level reporting system that staff had not followed in the above cases.

After the Exit Conference, the Plan provided a narrative describing its quality processes in the above cases, but not direct supporting evidence of its actions.

When the Plan does not take effective action to address needed improvements in the quality of care, repeated adverse healthcare events may occur.

San Diego GMC

5.1.3 Potential Quality Incidents (PQIs)

The Plan shall monitor, evaluate, and take effective action to address any needed improvements in the quality of care delivered by all providers rendering services on its behalf, in any setting (*Contract, Exhibit A, Attachment 4 (1)*).

Plan policy *CA.SCQC.QOC.005 Monitoring and Assessments of Quality Processes* stated the Plan continually assessed and improved the quality of care through a comprehensive and effective quality program.

The Plan did not take effective action to address needed improvements in the quality of care. It did not require action after three PQI investigations of cases involving severe health outcomes for members.

A verification study revealed three of three PQI investigations that did not show post case review at the Plan level for improvements to care processes:

- A quality investigation showed a member with a history of prior suicide attempts called and visited the Plan numerous times with complaints of ineffective psychiatric medications. The member attempted suicide in a Plan medical office.
- A quality investigation showed a pediatric member had multiple visits to his primary care physician and complained of arm pain for almost two years. A Plan specialist discovered a malignant tumor.

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- In a third case, a diabetic member with kidney failure came to the ER with signs of severe facial infection after recent ear surgery. The member required emergency surgery to remove infected facial tissue and subsequently passed away. PQI records showed:
 - A member at high risk for a poor outcome due to his medical condition was not initially admitted to the intensive care unit (ICU).
 - Facial tissue gas on a CAT scan was not identified as infection-related.
 - A question of delayed transfer to the ICU after admission and rapid worsening of the member's condition.

Plan policy CA.SCQC.QOC.005 described the Plan's quality investigation oversight. Policy NATL.DCSQ.002 *Peer Review and Evaluation of Licensed Independent Practitioner Performance* outlined the peer review process and severity level assignment after PQI investigation.

The Plan's post Exit Conference response did not indicate case review at the Plan level or in committee.

This may result in repeated adverse health outcomes for members.

Sacramento GMC

5.1.4 Preventive Care Guidelines

The Plan shall ensure that it uses the latest edition of the U.S. Preventive Services Task Force's (USPSTF) *Guide to Clinical Preventive Services* as a minimum guideline for delivering preventive services to adult members age 21 or older. The Plan must provide all preventive services identified as USPSTF "A" and "B" recommendations (*Contract, Exhibit A, Attachment 10 (6) (B) (1)*).

The Plan's 2018 Quality Program Description (QPD) stated it developed evidence based clinical practice guidelines to assist providers in delivering preventive care to members.

The Plan did not require that practitioners provide applicable USPSTF "A" and "B" preventive services to members when age and patient appropriate. The Plan did not include all USPSTF A and B recommended services in its 2018 publication *Your Guidebook*, a member resource describing Kaiser Permanente services. Recommendations did not match USPSTF descriptions.

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Plan preventive care guidelines showed deficiencies:

- KP National Guidelines advised providers to consider lung cancer screening for high-risk individuals, while the USPSTF absolutely recommended lung cancer screening, a B recommendation, for those at high risk.
- The most recent USPSTF's *Guide to Clinical Preventive Services* recommended lung cancer screening and using aspirin to prevent cardiovascular disease; both are B recommendations. The preventive care guidelines in the Plan's 2018 member guidebook did not recommend lung cancer screening or using aspirin to prevent cardiovascular problems.
- The USPSTF *Guide* recommended screening for colorectal cancer with stool testing, sigmoidoscopy, or colonoscopy for 50 to 75 year olds. The Plan's guidebook advised 50 and 75 year olds to screen with a stool test or sigmoidoscopy, and to consider colonoscopy as of age 40 if at risk for colorectal cancer. The USPSTF did not limit colonoscopy to high-risk individuals.

The Plan's annual provider letter stated practitioners could access preventive guidelines on internal KP websites. KP Clinical Practice Guidelines for breast, colorectal and cervical cancer screening matched USPSTF recommendations.

After a 2017 DHCS audit finding that it did not document the status of USPSTF preventive services in members' Initial Health Assessments (IHAs), the Plan responded it monitored application of preventive guidelines. It stated it used USPSTF and other evidence-based resources in developing and updating its own preventive measures, and that it was discussing the prioritization of USPSTF guidelines with DHCS. It had not corrected the deficiency by the time of the current DHCS audit.

When the Plan does not meet minimum standards for preventive care required by the contract, poor health outcomes for Medi-Cal members may result.

San Diego GMC

5.1.4 Preventive Care Guidelines

The Plan shall ensure that it uses the latest edition of the U.S. Preventive Services Task Force's (USPSTF) *Guide to Clinical Preventive Services* as a minimum guideline for delivering preventive services to adult members age 21 or older. The Plan must provide all preventive services identified as USPSTF "A" and "B" recommendations (*Contract, Exhibit A, Attachment 10 (6) (B) (1)*).

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The Plan's 2018 *Quality Program Description* (QPD) stated the Plan had created an integrated approach to health care that included prevention.

The Plan did not require that practitioners provide applicable USPSTF "A" and "B" preventive services to members when age and patient appropriate. The Plan did not include all USPSTF A and B recommended services in the preventive care section of its 2018 publication *Your Guidebook*, a member resource describing Kaiser Permanente services, or in its provider document *Preventive Care Services for Adults and Older Adults, Clinical Practice Guidelines*. Recommendations did not match USPSTF descriptions.

Plan preventive care guidelines showed deficiencies:

- KP National Guidelines advised providers to consider lung cancer screening for high-risk individuals, while the USPSTF absolutely recommended lung cancer screening, a B recommendation, for those at high risk.
- The most recent USPSTF *Guide to Clinical Preventive Services* recommended lung cancer screening and using aspirin to prevent cardiovascular disease; both are B recommendations. Neither the Plan's 2018 member guidebook nor its provider resource *Preventive Care Services for Adults and Older Adults, Clinical Practice Guidelines* included these.
- The USPSTF *Guide* did not recommend cervical cancer screening for women over 65 who had had adequate screening and were not at high risk. The San Diego guidebook stated 66 year old women who had had adequate screening did not need additional testing, but did not add that high risk was also a consideration.
- In 2014, the USPSTF *Guide* recommended screening adults with blood pressure greater than 135/80 for type 2 diabetes. The USPSTF next recommended screening obese or overweight 40 to 70 year olds. The Plan's San Diego guidebook recommended testing for type 2 diabetes starting at age 45 every 5 years.

The Plan's annual provider letter named the USPSTF as a source for KP's preventive care guidelines, which were located on an internal KP website. National Clinical Practice Guidelines for breast, colorectal and cervical cancer screening matched USPSTF recommendations.

After a 2017 DHCS audit finding that it did not document the status of USPSTF preventive services in members' Initial Health Assessments (IHAs), the Plan responded it monitored application of preventive guidelines. It stated it used USPSTF and other evidence-based resources in developing and updating its own preventive measures, and that it was discussing the prioritization of USPSTF guidelines with DHCS. It had not corrected the deficiency by the time of the current DHCS audit.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

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When the Plan does not meet minimum standards for preventive care required by the contract, poor health outcomes for Medi-Cal members may result.

Sacramento GMC

5.1.5 Provider Manual

The Plan shall maintain and implement appropriate procedures to keep contracting providers informed of the written QIS, its activities, and outcomes (*Contract, Exhibit A, Attachment 4 (5)*).

The Plan shall issue a Provider Manual and updates to the providers of Medi-Cal services. The manual and updates shall serve as a source of information to health care providers regarding services, policies, procedures, regulations, telephone access and special requirements regarding the Medi-Cal Managed Care program, including appeals, grievances and state fair hearings (*Contract, Exhibit A, Attachment 7 (4)*).

The Plan's *Annual TPMG (The Permanente Medical Group) Practitioner Communication, Quality and UM Policies* for the Plan's medical group stated the letter was a reference tool that communicated aspects of its QI and UM programs.

The Plan did not have a Provider Manual for its medical group (TPMG) that served as a provider resource for Medi-Cal managed care services, policies and procedures, regulations and special requirements. The Plan's *2018 Northern California HMO Provider Manual* for non-Kaiser doctors who contracted with the Plan did not inform HMO providers about Medi-Cal managed care services, policies and procedures, regulations and special requirements. The Plan's annual provider update did not contain Medi-Cal managed care requirements.

The Plans annual TPMG Provider communication letter did not inform TPMG practitioners of Medi-Cal specific services, policies and procedures, statutes, regulations, telephone access, appeals and grievances, state fair hearings and special requirements regarding the Medi-Cal Managed Care program.

The Plan's public website kp.org contained a Medi-call link that provided enrollment information but did not describe policies, procedures, requirements, or benefits specific to Medi-Cal members.

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In interviews, the Plan reported that TPMG providers easily accessed information about specific policies and processes, including those regarding UM, online or in consultation with physician leaders at their local facilities. It stated that providers did not consider lines of business when treating members so that all members received the same quality treatment. The annual letter served as a source of information for providers.

Without a comprehensive resource and updates containing information about Medi-Cal specific policies, procedures, requirements, and benefits, TPMG practitioners may be misinformed and may not provide members with medically necessary covered services.

San Diego GMC

5.1.5 Provider Manual

The Plan shall maintain and implement appropriate procedures to keep contracting Providers informed of the written QIS, its activities, and outcomes (*Contract, Exhibit A, Attachment 4 (5)*).

The Plan shall issue a Provider Manual and updates to the providers of Medi-Cal services. The manual and updates shall serve as a source of information to health care providers regarding policies and procedures, statutes, regulations, telephone access and special requirements regarding the Medi-Cal Managed Care program (*Contract, Exhibit A, Attachment 7 (4)*).

The Plan's 2017-2018 *SCPMG (Southern California Permanente Medical Group) Practitioner Staff Annual Quality Letter* stated the letter annually communicated to all employees, providers and practitioners the Plans policies, processes and practices. The letter updated both contracted and the Plan medical group (SCPMG) providers about Medi-Cal managed care changes.

The Plan's *Benefits and Services for Kaiser Permanente's Medi-Cal Managed Care Members /Provider Quick Reference Guide (SCAL)* contained information about Medi-Cal managed care.

The Plan did not have a Provider Manual for Plan medical group healthcare practitioners.

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The Plan's 2018 annual newsletter stated that newly hired physicians received the *Provider Quick Reference Guide/Benefits and Services for Kaiser Permanente's Medi-Cal Managed Care Members* during their KP onboarding process. The 11-page publication contained information about Medi-Cal managed care but was not comprehensive. It did not include Medi-Cal specific-information for acupuncture services, early and periodic screening, diagnosis and treatment for members under 21 years old, preventive services, and dental anesthesia, or describe details about grievance, appeal and State Fair Hearing filing.

The Plan's public website kp.org contained a Medi-Cal link that provided enrollment information but did not describe policies, procedures, requirements, or benefits specific to Medi-Cal members.

In interviews, the Plan reported that SCPMG providers easily accessed information about specific policies and processes online or in consultation with physician leaders at their local facilities. It stated that providers did not consider lines of business when treating members so that all members received the same quality treatment. The annual letter served as a source of information for providers.

Without a comprehensive resource and updates containing information about Medi-Cal specific policies, procedures, requirements, and benefits, SCPMG practitioners may be misinformed and may not provide members with medically necessary covered services.

RECOMMENDATION(S):

Sacramento GMC

- 5.1.1** Revise Plan policies and processes to require routine reporting from the GMC QOC to the governing body.
- 5.1.2** Revise the Plan's written description of the quality program and its organizational charts to include the GMC QOC.

Sacramento and San Diego GMC

- 5.1.3** Revise Plan policies and processes to ensure the Plan takes effective action and addresses any needed improvements in the quality of care and services delivered.

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5.1.4 Revise Plan policies and processes to ensure that the Plan uses the latest edition of the USPSTF Guide to Clinical Preventive Services as a minimum guideline and provides all preventive services identified as USPSTF “A” and “B” recommendations.

Sacramento GMC

5.1.5 Develop and implement a Provider Manual that informs TPMG health care practitioners about the Medi-Cal Managed Care program. Revise Plan processes to include Medi-Cal managed care updates in the annual provider newsletter. Revise Plan processes to include comprehensive Medi-Cal Managed Care program information in the *Northern California HMO Provider Manual*.

San Diego GMC

5.1.5 Develop and implement a Provider Manual that informs SCPMG health care practitioners about the Medi-Cal Managed Care program.

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5.2

PROVIDER QUALIFICATIONS

Credentialing and Re-credentialing:

Contractor shall develop and maintain written policies and procedures that include initial credentialing, recredentialing, recertification, and reappointment of Physicians including Primary Care Physicians and specialists in accordance with the MMCD Policy Letter 02-03, Credentialing and Re-credentialing.

Contractor shall ensure those policies and procedures are reviewed and approved by the governing body, or designee. Contractor shall ensure that the responsibility for recommendations regarding credentialing decisions will rest with a credentialing committee or other peer review body.

GMC Contract A.4.12

Provider Qualifications:

All providers of Covered Services must be qualified in accordance with current applicable legal, professional, and technical standards and appropriately licensed, certified or registered....Providers that have been terminated from either Medicare or Medicaid/Medi-Cal cannot participate in Contractor's provider network.

GMC Contract A.4.12.A

Provider Training:

Contractor shall ensure that all providers receive training regarding the Medi-Cal Managed Care program in order to operate in full compliance with the Contract and all applicable Federal and State statutes and regulations. Contractor shall ensure that provider training relates to Medi-Cal Managed Care services, policies, procedures and any modifications to existing services, policies or procedures. Training shall include methods for sharing information between Contractor, provider, Member and/or other healthcare professionals. Contractor shall conduct training for all providers within 10 working days after the Contractor places a newly contracted provider on active status...Contractor shall ensure that ongoing training is conducted when deemed necessary by either the Contractor or DHCS.

GMC Contract A.7.5

Delegated Credentialing:

Contractor may delegate credentialing and recredentialing activities. If Contractor delegates these activities, Contractor shall comply with Provision 6, Delegation of Quality Improvement Activities...

GMC Contract A.4.12.B

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: KP Cal, LLC – Kaiser Permanente Sacramento and San Diego GMC

AUDIT PERIOD: September 1, 2017 to August 31, 2018

DATE OF AUDIT: October 1, 2018 to October 12, 2018

5.2

PROVIDER QUALIFICATIONS

Disciplinary Actions:

Contractor shall implement and maintain a system for the reporting of serious quality deficiencies that result in suspension or termination of a practitioner to the appropriate authorities. Contractor shall implement and maintain policies and procedures for disciplinary actions including reducing, suspending, or terminating a practitioner's privileges. Contractor shall implement and maintain a provider appeal process.
GMC Contract A.4.12.D

SUMMARY OF FINDING(S):

Sacramento GMC

5.2.1 Training for Newly Contracted Non-Physician Providers

The Plan is required to conduct training for all providers within 10 working days after placing newly contracted providers on active status. (*Contract, Exhibit A, Attachment 7 (5) (A)*)

The Contract defines a provider as a physician, nurse, technician, teacher, researcher, hospital, home health agency, nursing home, or any other individual or institution that contracts with the Plan to provide medical services to members. (*Contract, Exhibit E, Attachment 1, Definitions*)

Plan policy *NATL.HR.012 Compliance Training Policy* stated new non-physician providers must complete Medi-Cal compliance training within 10 days of hire.

The Plan did not provide Medi-Cal training for new non-physician providers within 10 working days of active status.

A verification study revealed 24 of 25 non-physician providers hired between May 2018 and August 2018 did not complete training within 10 working days.

The prior DHCS audit found that the Plan did not provide training for non-physician providers. As a corrective action, the Plan developed and implemented a process to provide online training to providers. The process was finalized in May 2018. However, training for newly contracted non-physician providers was still not conducted within 10 working days.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: KP Cal, LLC – Kaiser Permanente Sacramento and San Diego GMC

AUDIT PERIOD: September 1, 2017 to August 31, 2018

DATE OF AUDIT: October 1, 2018 to October 12, 2018

If the Plan does not ensure new provider training is completed within 10 working days, it cannot ensure that providers are informed of Medi-Cal requirements.

This is a repeat finding.

San Diego GMC

5.2.1 Training for Newly Contracted Non-Physician Providers

The Plan is required to conduct training for all providers within 10 working days after placing newly contracted providers on active status. (*Contract, Exhibit A, Attachment 7 (5) (A)*)

The Contract defines a provider as a physician, nurse, technician, teacher, researcher, hospital, home health agency, nursing home, or any other individual or institution that contracts with the Plan to provide medical services to members. (*Contract, Exhibit E, Attachment 1, Definitions*)

Plan policy *NATL.HR.012 Compliance Training Policy* stated new non-physician providers must complete Medi-Cal compliance training within 10 days of hire.

The Plan did not provide Medi-Cal training for new non-physician providers within 10 working days of active status.

A verification study revealed 25 of 25 non-physician providers hired between May 2018 and August 2018 did not complete training within 10 working days.

The prior DHCS audit found that the Plan did not provide training for non-physician providers. As a corrective action, the Plan developed and implemented a process to provide online training to providers. The process was finalized in May 2018. However, training for newly contracted non-physician providers was still not conducted within 10 working days.

If the Plan does not ensure new provider training is completed within 10 working days, it cannot ensure that providers are informed of Medi-Cal requirements.

This is a repeat finding.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖
PLAN: KP Cal, LLC – Kaiser Permanente Sacramento and San Diego GMC
AUDIT PERIOD: September 1, 2017 to August 31, 2018 DATE OF AUDIT: October 1, 2018 to October 12, 2018

Sacramento GMC

5.2.2 Training for Newly Contracted Physician Providers

The Plan is required to conduct training for all providers within 10 working days after placing newly contracted providers on active status. (*Contract, Exhibit A, Attachment 7 (5) (A)*)

The Contract defines a provider as a physician, nurse, technician, teacher, researcher, hospital, home health agency, nursing home, or any other individual or institution that contracts with the Plan to provide medical services to members. (*Contract, Exhibit E, Attachment 1, Definitions*)

The Plan did not provide Medi-Cal training for new physician providers within 10 working days of active status.

A verification study revealed three of six newly hired physicians did not complete training within 10 working days. Attestations were signed between 40 and 258 working days.

The Plan cited lack of local oversight as the reason for the error. Medical centers were still transitioning the training/onboarding process from paper to electronic.

If the Plan does not ensure new provider training is completed within 10 working days, it cannot ensure that providers are informed of Medi-Cal requirements.

RECOMMENDATION(S):

Sacramento and San Diego GMC

5.2.1 Ensure all new non-physician providers receive new provider training within 10 working days after the Plan places a newly contracted provider on active status.

Sacramento GMC

5.2.2 Ensure all new physician providers receive new provider training within 10 working days after the Plan places a newly contracted provider on active status.

MEDICAL REVIEW – NORTH I SECTION
AUDITS AND INVESTIGATIONS
DEPARTMENT OF HEALTH CARE SERVICES

REPORT ON THE MEDICAL AUDIT OF

KP Cal, LLC
Kaiser Permanente GMC

Contract Number: 07-65850 Sacramento
09-86160 San Diego

State Supported Services

Audit Period: September 1, 2017
Through
August 31, 2018

Report Issued: May 20, 2019

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INTRODUCTION

This report presents the audit findings of KP Cal, LLC State Supported Services Contract No. 07-65850 for Sacramento GMC, Contract No. 09-86160 for San Diego GMC. The State Supported Services Contracts cover contracted abortion services.

The onsite review was conducted from October 1 through October 12, 2018. The audit period is September 1, 2017 through August 31, 2018 and consisted of document review of materials supplied by the Plan and interviews conducted onsite.

Thirty State Supported Services claims were reviewed for appropriate and timely adjudication.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: KP Cal, LLC. – Kaiser Permanente Sacramento and San Diego GMC

AUDIT PERIOD: September 1, 2017 to August 31, 2018

DATE OF AUDIT: October 1, 2018 to October 12, 2018

STATE SUPPORTED SERVICES CONTRACT REQUIREMENTS

Abortion

Contractor agrees to provide, or arrange to provide, to eligible Members the following State Supported Services:

Current Procedural Coding System Codes: 59840 through 59857*

HCFA Common Procedure Coding System Codes: X1516, X1518, X7724, X7726, Z0336*

**These codes are subject to change upon the Department of Health Services' (DHS') implementation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) electronic transaction and code sets provisions. Such changes shall not require an amendment to this Contract.*

State Supported Services Contract Exhibit A.1

SUMMARY OF FINDING(S):

There were no deficiencies identified in the current audit.

RECOMMENDATION(S):

None